

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

16605

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16607

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prin &amp; George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>222 Washington Bl.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>JAMES BROWNING ABBOTT</b>		4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1966</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3.19.1914</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>ERNEST ABBOTT</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA BROWNING</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Records, Mt. Wilson State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1002.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>11.26</b> , 19 <b>66</b> , to <b>12.1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12.1</b> , 19 <b>66</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.																			
22a. SIGNATURE <b>Wm. Newcomer</b> 22b. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>														22c. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <b>12.1.1966</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-6-66</b>				23b. DATE THEREOF <b>12-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calverton Med School</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>											
24. FUNERAL DIRECTOR <b>Navell Funeral Home</b>				24a. ADDRESS <b>Phesville 6-8</b>		24b. REC'D BY REGISTRAR <b>DEC 7 1966</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

15505

15505

Belmont County

Mount Vernon

Mount Vernon State Hospital

JAMES BROWN

W. M.

INVEST

Mount Vernon State Hospital



Mount Vernon State Hospital

8



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16606

CERTIFICATE OF DEATH

16608

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>8/30/61</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Professional House, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Starrett Alexander</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/179</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Parkersburg, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hunter Holmes Moss</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Blair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. Holmes Alexander, 922 25th St., Wash., D.C.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Aug. 31</u> , 19 <u>64</u> , to <u>Dec. 9</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Dec. 9</u> , 19 <u>66</u> , and that death occurred at <u>4:00 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David I. Miller</u> M.D.		22b. DATE SIGNED <u>12-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller, M.D.</u>		22d. ADDRESS <u>Owings Mills, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 13, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Owings Mills, Maryland</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 14 1966</u>	

18884

STATE OF TEXAS

18884

18884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G384 1/11/67 mh

16607

CERTIFICATE OF DEATH

16609

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN Tb <b>30-4</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Altwater</b> Last <b>Altwater</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce-Own Bus.</b>	9. AGE (In years lost birthday) <b>95</b> yrs.
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Carl Hartung</b> <b>818 8th Ave./-Sommerville, N. J.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardio Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 29, 1956</b> , to <b>Dec 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 30, 1966</b> , and that death occurred at <b>2:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Harry L. Knipp</b>		22b. DATE SIGNED <b>Jan 3 '67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp, M.D.</b>		22d. ADDRESS <b>4116 Edmondson Av.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-3-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. - 410b Edmondson Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10000

CERTIFICATE OF DEATH

10000

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant

11. Name of informant  
12. Address of informant  
13. Signature of informant  
14. Date of completion

15. Name of registrar  
16. Address of registrar  
17. Signature of registrar  
18. Date of registration

19. Name of informant  
20. Address of informant  
21. Signature of informant  
22. Date of completion

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16608					16610						
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City (7)</u> d. STREET ADDRESS <u>2206 Luskwood Drive</u>						
3. NAME OF DECEASED (Type or print) <u>Gertrude</u> First Middle Last <u>Anders</u>					4. DATE OF DEATH Month Day Year <u>December 20 1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/13</u>		9. AGE (in years last birthday) <u>53</u> yrs. <u>1</u> Months <u>29</u> Days <u></u> Hours <u></u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing Instructor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wye Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry Denny</u>					14. MOTHER'S MAIDEN NAME <u>Sparks</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>Patient's Chart</u>						
17. INFORMANT <u>Patient's Chart</u>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Cardio - Respiratory Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u></u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										INTERVAL BETWEEN ONSET AND DEATH <u>12-17-1966</u> <u>12-20-1966</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (H) (this hospital) attended the deceased from <u>Dec 17</u> , 19 <u>66</u> , to <u>Dec 20</u> , 19 <u>66</u> , that (H) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>66</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dennis Chan</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>Dec 20, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN</u>					22d. ADDRESS <u>GB MC</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE THEREOF <u>Dec. 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Balto. Co., Md.</u>				
24. FUNERAL DIRECTOR <u>Loring Byers, 8728 Liberty Rd; Randallstown, Md.</u>					ADDRESS <u>21133</u>		25a. REC'D BY REGISTRAR <u>DEC 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

16609

16611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER Baltimore Medical Center</u>				e. STREET ADDRESS <u>5104 Springlake Way</u>					
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>GILBERT</u> Middle <u>Armstrong</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-24-06</u>			
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Exec Arundel Corp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburgh PENNA</u>		11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Douglas W. Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Annie E Morgan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>097-09-5966</u>		17. INFORMANT Address <u>Patient's CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>456X Congestive Heart Failure</u> DUE TO (b) <u>Calcific Aortitis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 27th, 1966</u> , to <u>Dec. 8th, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 8th, 1966</u> , and that death occurred at <u>9:30 M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M. MacGregor</u>				22b. DATE SIGNED <u>12-8-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>M. MACGREGOR</u>				22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/10/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				25a. REC'D BY REGISTRAR <u>4905 York Road</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>DEC 12 1966</u>					



Exclusive Listing

007-02-0000 Patients Chart

no

Douglas W Armstrong

Annie E McCardan

Retired Executives Club Pittsburgh, Penna USA

M W

02-00-00

BO

William Gilbert Armstrong

Greater Baltimore Medical Center Springlake Way

12 days Baltimore - Springfield

Baltimore

Marvyn

Baltimore

10011

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

## CERTIFICATE OF DEATH

16610

16612

1. PLACE OF BIRTH a. COUNTY BALTO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY 13.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SHADY NOOK HOME				d. STREET ADDRESS 185 LIGON RD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CATHERINE E. AULBACH First Middle Last		4. DATE OF DEATH 12/19 1966 Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/15/74	9. AGE (In years lost birthday) 92 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK FRITZGES		14. MOTHER'S MAIDEN NAME MARGARET SUSSAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address DORIS SCHMEISER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis (b) Coronary Arteriosclerosis (c) Age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH - 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 19193 to 12/17, 1966 that (I) (we) lost the deceased alive on 12/7 1966, and that death occurred at 6 AM, from causes and on the date stated above.					
22a. SIGNATURE Cliff Ratliff		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12/19/66		
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR		22d. ADDRESS 4605 Edmondson Ave #27			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/21/66	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	23d. LOCATION (City or Town) (County) (State) BALTO MD		
24. FUNERAL DIRECTOR E. S. MACNABB 301 FREDERICK RD 21228		25a. REC'D BY REGISTRAR DATE DEC 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

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RECEIVED OF DEPT.  
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16611

CERTIFICATE OF DEATH

16613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE CITY</b> c. LENGTH OF STAY IN 1b <b>58 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8705 LOCKBEND DRIVE</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE CITY</b> d. STREET ADDRESS <b>8705 LOCKBEND DR.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>WALTON</b> Last <b>AULL</b>			4. DATE OF DEATH Month <b>12</b> Day <b>29</b> Year <b>1966</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-31-1908</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>58</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PACKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE TOOLS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. CITY MD.</b>	
13. FATHER'S NAME <b>HERBERT WILLIAM AULL</b>			14. MOTHER'S MAIDEN NAME <b>EVELLE RIGTER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-07-3073</b>		17. INFORMANT <b>WIFE</b> Address <b>ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>150X CIRCULATORY COLLAPSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b> <b>8 AM</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1965</b> to <b>DEC 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>DEC 1, 1966</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Samuel A. O'Mansky</b>			22b. DATE SIGNED <b>Dec 29 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL ISAAC O'MANSKY</b>			22d. ADDRESS <b>8523 LOCKRAVEN BLVD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-31-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road 36</b>			25a. REC'D BY REGISTRAR <b>JAN 3 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

10013

10013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16612

## CERTIFICATE OF DEATH

16614

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>46yrs.</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1516 Burnwood Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Joseph</b> Last <b>Azzaro</b>		4. DATE OF DEATH Month <b>12</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/01</b>
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wilmington, Del.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) <b>215-05-0587 A</b>		16. SOCIAL SECURITY NO. <b>215-05-0587 A</b>	
17. INFORMANT (nee Culotta) <b>Mary Azzaro, wife, above</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>66</b> , to <b>12/5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/5</b> , 19 <b>66</b> , and that death occurred on <b>8:10 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>12/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez</b>		22d. ADDRESS <b>St. Joseph Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

12813

RECEIVED OF MAIL

12813

12813



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16613					16615					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY			
Baltimore		Baltimore			Maryland		Baltimore			
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
22 days		Greater Baltimore Medical Center			Baltimore, Md - 21212-30-4		7 E Lake Ave			
e. IS RESIDENCE ON A FARM?		3. NAME OF DECEASED (Type or print)			e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Melvin ALFRED BARNHART			4. DATE OF DEATH		Month Day Year			
12 14 1966		5. SEX			6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		CAU		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/6/01		9. AGE (in years last birthday)		
65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Plumbing & Heating		Self-employed		Baltimore, Md.		U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
George BARNHART					McGee					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					
No					212-27-7719					
17. INFORMANT					Address					
Patient's Chart										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Massive Pulm. Embolism										
DUE TO (b) Myocardial Infarction										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year										
20d. INJURY OCCURRED										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from 11-27-1966, to 12-14, 1966, that (I) (we) last saw the deceased alive on 12-14 1966, and that death occurred at 7:30 AM, from the causes and on the date stated above.										
22a. SIGNATURE										
22b. DATE SIGNED										
22c. PHYSICIAN'S NAME (Type)										
22d. ADDRESS										
22e. REC'D BY REGISTRAR										
22f. REGISTRAR'S SIGNATURE										
23a. BURIAL, CREMATION, REMOVAL (Specify)										
23b. DATE THEREOF										
23c. NAME OF CEMETERY OR CREMATORY										
23d. LOCATION (City, town or county) (State)										
24. FUNERAL DIRECTOR										
25a. REC'D BY REGISTRAR										
25b. REGISTRAR'S SIGNATURE										

23a. Burial 23b. 12-17-66 23c. Loudon Park 23d. Baltimore Balto Md.

24. Wm. Cook-Brooks Towson 1050 York Rd. 25a. DEC 19 1966 25b. Charles Judge

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Buttmore

Partners

23rd Nov 1947 - 24th Nov 1947

10/10/19

Albert Einstein

UAD M

10/2/01

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Self-employed

Baltimore, Md.

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George Brinkman

 $\text{ad}^3 M$ 

Handwritten: *Handwritten*

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Proprietary Information

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Rebuck

RAM K. CHAKRABARTY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16614

16616

1. PLACE OF DEATH a. COUNTY <i>BALTO</i>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Greater Baltimore Medical Center</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greater Baltimore Medical Center</i>			e. STREET ADDRESS <i>6334 Dogwood Rd.</i>		
3. NAME OF DECEASED (Type or print) <i>CATHERINE PAULINE BAUHOFF</i>			4. DATE OF DEATH Month <i>12</i> Day <i>21</i> Year <i>1966</i>		
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i>	8. DATE OF BIRTH <i>4-1-10</i>	9. AGE (In years last birthday) <i>56</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bauhof Bakery</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore - Maryland</i>		
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>John Kammer</i>			14. MOTHER'S MAIDEN NAME <i>ANNA SCHULTZ</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>211-40-1844</i>			16. SOCIAL SECURITY NO. <i>211-40-1844</i>		
17. INFORMANT <i>Robert Bauhof</i>			Address <i>9126 Liberty Rd. - 21133</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of breast with pulmonary metastasis &amp; pleural effusion</i> (c) <i>metastasis &amp; pleural effusion</i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>12/21 A.M. 1966</i> to <i>12/21 P.M. 1966</i> , that (I) (we) last saw the deceased alive on <i>12/21 A.M. 1966</i> , and that death occurred at <i>2:00 P.M.</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Francis L. Coates</i>			22b. DATE SIGNED <i>12/21/66</i>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>12-24-66-Burial</i>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>Witzke F.D.-4101 Edmondson Ave.</i>			25a. REC'D BY REGISTRAR <i>DEC 22 1966</i>		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION

10010

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8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16615 CERTIFICATE OF DEATH 16617											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>COUNTY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TIMONIUM</b> <b>BALTO. CO.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>31 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium, Md</b> <b>03-1</b>				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER 1504 DULANEY VALLEY RD</b>											
3. NAME OF DECEASED (Type or print) <b>George HERBERT BAUSMAN</b>			First Middle Last			4. DATE OF DEATH <b>12 13 1966</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/1878</b>		9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANUFACTURER -</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Inventor</b>				11. BIRTHPLACE (County & State, or foreign country) <b>PLEASANT HILL MD</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John GEORGE BAUSMAN</b>				14. MOTHER'S MAIDEN NAME <b>Tolah N. BAUSMAN SWEMM</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Spanish-American</b>				16. SOCIAL SECURITY NO. <b>216-32-8271</b>				17. INFORMANT <b>TOLAH N. BAUSMAN - Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Metastatic carcinoma</b> DUE TO (c) <b>Carcinoma of prostate</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 13, 1966</b> , to <b>December 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 13, 1966</b> , and that death occurred at <b>2 P M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Kuwilsky</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>12-13-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dora C. Kuwilsky</b>						22d. ADDRESS <b>Greater Baltimore Medical Center</b>					
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>12-17-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon PK Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>			
24. FUNERAL DIRECTOR <b>Edward H. Ansdorf</b>						25a. REC'D BY REGISTRAR <b>4600 Liberty Hgts. Avenue</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
DATE <b>DEC 15 1966</b>											

Dora C. Kowalski  
 Kinship  
 Dec 12 1966  
 Nov 13 5 1/2  
 Dec 13 1966  
 x 15-17 66  
 Greater Baltimore Medical Center

Cardiac primary failure  
 Metastatic carcinoma  
 Carcinoma of prostate

George Bazman  
~~George Bazman~~  
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M CAN ✓ 11/23/1978 8  
 GEORGE HILL MD

Greater Baltimore Medical Center 1504 Dunbar Valley Rd  
 George Herbert Bazman 12 13 66  
 31 days

Baltimore County Maryland

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16616

**CERTIFICATE OF DEATH**

16618

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalltown</u>			c. LENGTH OF STAY IN TB <u>12 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>				d. STREET ADDRESS <u>2653 Loyola Southway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Peter Bayer</u>				4. DATE OF DEATH Month Day Year <u>December 20, 19 66</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-02</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>H.D. Dryer-Wood Work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Bayer</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Schuek</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW 1 Yes</u>		16. SOCIAL SECURITY NO. <u>216-03-1458</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Massive Pulmonary Embolus</u> (b) <u>interolateral myocardial infarct + thrombi</u> DUE TO <u>Atherosclerotic heart dis</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>no</u> <u>days</u> <u>Yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-9-1966</u> , to <u>12-20-1966</u> , that (I) (we) last saw the deceased alive on <u>12-20-1966</u> , and that death occurred at <u>7:20 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Edward Sherrer, Jr MD</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>21 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward Sherrer, Jr MD</u>				22d. ADDRESS <u>Balto. Co. Gen. Hosp.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ohebe Shalom</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Solomon &amp; Bros. Inc., 6010 Reisterstown Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

16617

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16619

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		<u>131</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6503 Langdale Road</u>		d. STREET ADDRESS <u>6503 Langdale Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary E. Becker</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Wienekes</u>		16. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		18. SOCIAL SECURITY NO. <u>218 305541A</u>	
19. INFORMANT <u>Cotton Sheff</u>		Address <u>Field 6503 Langdale Road</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular-accident</u> <u>422.1</u> DUE TO (b) <u>A.S.C.V.D.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1966</u> , to <u>Dec 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 29, 1966</u> , and that death occurred at <u>10:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. B. Gardner</u>		22b. DATE SIGNED <u>12/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. M. B. GARDNER</u>		22d. ADDRESS <u>Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balt. Md.</u>
24. FUNERAL DIRECTOR <u>Philip F. Coach</u>		25a. REC'D BY REGISTRAR <u>1211 Chesaco Ave</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 3 1967</u>	

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1881

RECEIVED  
JAN 10 1881  
U. S. DEPT. OF AGRICULTURE  
WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16618

CERTIFICATE OF DEATH

16620

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, 7620 York Rd. 21204</b>		d. STREET ADDRESS <b>1923 E. Belvedere Ave.</b> <del>8505 Loch Raven Blvd. 21212</del>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>JOHN</b> Last <b>BELT</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-10-190</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>(Sheet Metal)</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Belt</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Kenny</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown No</b>		16. SOCIAL SECURITY NO. <b>215-16-6677</b>	
17. INFORMANT <b>Wife: Antoinette 1924 Belvedere Ave. #12</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1) Bleeding esophageal varices</b> DUE TO <b>2) Leneche's cirrhosis</b> (b) <b>3) Aspiration pneumonia</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-25</b> , 19 <b>66</b> , to <b>12-25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>66</b> , and that death occurred at <b>12:15</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Govinda Rao</i>		22b. DATE SIGNED <b>12-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Govinda Rao</b>		22d. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/28/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05381

# 1231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16619

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16621

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1005 Bittersweet Ct.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1005 Bittersweet Ct.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sylvia</u> First <u>Bidick</u> Middle <u>BERMAN</u> Last		4. DATE OF DEATH <u>12</u> Month <u>16</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/28/17</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MORRIS ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE BERGER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Morris Berman</u> Address <u>1005 Bittersweet Ct.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>out to take pneumonia &amp; deaminate/cy.</u> (c) <u>Carcinoma of the breast</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>66</u> , to <u>12/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>66</u> , and that death occurred at <u>2 P</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Merrill I. Berman</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Merrill I. Berman, M.D.</u>				22d. ADDRESS <u>645 W Redwood St. Balto Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Southern Avenue</u>		23d. LOCATION (City, town or county) (State) <u>Balto, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis + Son, Inc - 3319 OLYMPIA</u> ADDRESS <u>AUG</u>				25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16620

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16622

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm Md.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm Md.</b>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenarm Rd. 1 Mile S. of Glenarm</b>				d. STREET ADDRESS <b>710 Longreen Pike</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>CHARLES</b> Last <b>BIENSACH</b>				4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-28-1922</b>		9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas station</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Biensach</b>				14. MOTHER'S MAIDEN NAME <b>Lena Wolf</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-14-4902</b>		17. INFORMANT Address <b>Glenarm 21057</b> <b>Mrs Betty L. Biesach 710 Longreen Pike</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>819.4 IMMEDIATE CAUSE (a) Multiple Traumatic Injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto-Fixed Object Accident - Deceased Was Driver</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>7:30</b> p.m. <b>12 20 1966</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Glenarm Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b>		EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>12/21/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-23-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Perry Hall, Maryland</b>	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16621					16623				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3121 Gartside Ave. Balt 21207</b>					d. STREET ADDRESS <b>3121 Gartside Ave.</b>				
3. NAME OF DECEASED (Type or print) <b>Sylvester J. Biondo</b>					4. DATE OF DEATH Month <b>Dec.</b> Day <b>12</b> Year <b>19 66</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/27/1925</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trim Dept.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Salvadore Biondo</b>					14. MOTHER'S MAIDEN NAME <b>Josephine Culotta</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>W.W. II Yes</b>			16. SOCIAL SECURITY NO. <b>216-20-1701</b>		17. INFORMANT Address <b>Mrs. Anita Biondo-3121 Gartside Ave. 21207</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5271</b> DUE TO <b>Cor pulmonale</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Chronic emphysema</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>Few years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>Dec 12, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 12, 1966</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Paul H Royce</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul Royce</b>					22d. ADDRESS <b>1403 Foley Lane-Balt. Md. 21208</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>12/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Balt., Md. 21207</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>					25a. REC'D BY REGISTRAR <b>DEC 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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3121 Garfield Ave. , Half NW

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Washington, D.C.

Calvin K. Moore

110-20-1001 Mrs. Alice Moore-3121 Garfield Ave. NW

110-20-1001

110-20-1001 Mrs. Alice Moore-3121 Garfield Ave. NW

Dr. Paul Moore

110-20-1001

Woodman Cemetery

110-20-1001

110-20-1001

110-20-1001 Mrs. Alice Moore-3121 Garfield Ave. NW

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16622

CERTIFICATE OF DEATH

16624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE - 28</b> c. LENGTH OF STAY IN Tb <b>30.4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shady Nook Nursing Home-</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret S. Birch</b> First Middle Last 5. SEX <b>F</b> 6. COLOR OR RACE <b>Wh</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <b>Dec. 3</b> Month Day Year 8. DATE OF BIRTH <b>May 15, 1878</b> 9. AGE (In years less birthday) yrs. <b>88</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Ireland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b> 12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>	
13. FATHER'S NAME <b>Late - Mathew Stapleton</b>		14. MOTHER'S MAIDEN NAME <b>Late - Johanna</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Joseph Abbott</b> 17. INFORMANT <b>804 Woodington Rd.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Anteroselectic cardiovascular disease</b> DUE TO (b) <b>1 yr +</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>1 yr +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>65</b> , to <b>Dec. 3</b> , 19 <b>66</b> , that (I) (we) saw the deceased alive on <b>Dec 3</b> , 19 <b>66</b> , and that death occurred at <b>12:5 P.</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>John A. Nesbitt, Jr.</b> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <b>12-5-66</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>1009 Frederick Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b> 25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16623

## CERTIFICATE OF DEATH

16625

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>4711 Williston Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Charles H. Bissett Sr.</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Dec. 26 1966 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-96 1888</b>		9. AGE (In years last birthday) yrs. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Bissett</b>				14. MOTHER'S MAIDEN NAME <b>Mary Conroy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-18-5050</b>		17. INFORMANT <b>Charles H. Bissett, Jr.</b> Address <b>Spring Grove State Hospital</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HAEMATURIA - ACUTE PYELONEPHRITIS</b> (b) <b>CEREBROVASCULAR INSUFFICIENCY - CARDIOMEGALY</b> (c) <b>GENERALISED ARTERIO SCLEROSIS (SEVERE)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>12-8-66</b> , 19 <b>66</b> , to <b>12/26/1966</b> , that (I) (we) last saw the deceased alive on <b>12/26/1966</b> , and that death occurred at <b>10 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>A. Taheri</b>				22b. DATE SIGNED <b>12/26/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Amanollah Taheri</b>	
22d. ADDRESS <b>Spring Grove State Hospital</b> <b>Catonsville, Maryland 21228</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Witzke F.D.--4101 Edmondson Ave.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16624

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16626

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1 Warren Lodge Ct. Apt 6 C</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Columbiana</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lisbon</b> d. STREET ADDRESS <b>432 W. <del>W</del> Washington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Raymond Clyde Blair</b> First Middle Last 5. SEX <b>M</b> 6. COLOR OR RACE <b>Cauc</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <b>12, 31, 66</b> Month Day Year 19 8. DATE OF BIRTH <b>Sept 23, 1891</b> 9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Mgr.</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Nat. Screw Co</b>		11. BIRTHPLACE (State or foreign country) <b>Lisbon, Ohio</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Benton Blair</b>		14. MOTHER'S MAIDEN NAME <b>Martha McLaughlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>176 01 6776</b>	
17. INFORMANT <b>Thomas Blair</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Sudden 74 Days</b>		INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE <b>74 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>12/31/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-4-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lisbon</b>		23d. LOCATION (City or Town) (County) (State) <b>Lisbon, Ohio Columbiana</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b> ADDRESS		25a. REC'D BY REGISTRAR <b>JAN 4 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10056

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16625

CERTIFICATE OF DEATH

16627

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>3yr. 10mo. 26da</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fresland</b> <b>03.1</b> d. STREET ADDRESS <b>East Ruhl Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ANNA E BLEVINS</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>December 30 1966</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2-14-90</b>		<b>9. AGE</b> (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Mfg.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>Edward Blevins</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary (Unknown)</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>				<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>		<b>17. INFORMANT</b> Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchial pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2-4-63</u>, 19<u>  </u>, to <u>12-30</u>, 19<u>66</u>, that (he) (we) last saw the deceased alive on <u>12-30</u>, 19<u>66</u>, and that death occurred at <u>11.00</u>, from causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>Allen W. Lane</i>				<b>22b. DATE SIGNED</b> <b>12-30-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Allen W. Lane, M.D.</b>			
<b>22d. ADDRESS</b> <b>Spring Grove State Hospt.</b>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					
<b>23b. DATE THEREOF</b> <b>Jan. 2, 1967</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. John the Baptist</b>				<b>23d. LOCATION (City or Town) (County) (State)</b> <b>New Freedom Pa.</b>	
<b>24. FUNERAL DIRECTOR</b> <i>Jacob Kuntzstein, New Freedom, Pa.</i>				<b>25a. REC'D BY REGISTRAR</b> <b>JAN 4 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10883

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Mr. J. W. Lane, Jr.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16626 CERTIFICATE OF DEATH 16628

1. PLACE OF DEATH a. COUNTY <b>Baltimore,</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN Ib <b>XXX 11 days</b> Rt. 140 Finksburg 06.2			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center 6701 N. Charles St. Balto. Md.</b>			d. STREET ADDRESS <b>RURAL RT #2 FINKSBURG</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>XROSSKEY SHERMAN ADDISON BOSLEY</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>13</b> Year <b>1966</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-99</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co. Md.</b>	
13. FATHER'S NAME <b>John Bosley</b>			14. MOTHER'S MAIDEN NAME <b>Webster, ROSE LEE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-10-8748A</b>		17. INFORMANT <b>Medical Record</b> Address <b>6701 N CHARLES ST. BALTO. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b> <b>163X</b> DUE TO (b) <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Carcinoma of lung.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-02</b> , 19 <b>66</b> , to <b>12-13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-13</b> , 19 <b>66</b> , and that death occurred at <b>7:55</b> AM, from the causes and on the date stated above.					
22a. SIGNATURE <b>R. W. Smith</b>			22b. DATE SIGNED <b>12-13-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>R. W. Smith, M.D.</b>			22d. ADDRESS <b>6701 N. Charles St. Balto. Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM</b>		23d. LOCATION (City, town or county) (State) <b>WESTMINSTER CARROLL MD.</b>
24. FUNERAL DIRECTOR <b>James G. Saffell</b>			25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1883

1883

Carcinoma of lung  
Metastatic  
Carcinoma of lung

12-12-11 14-13-11

12-12-11

R. W. Smith

X 12-13-11

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16627

16629

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> 1m0 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Merrill Rd.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> 03.1 d. STREET ADDRESS <b>5 Merrill</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Charles Wesley Bradley</b> First Middle Last <b>5. SEX</b> <b>M</b> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>July 31 1900</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <b>66</b> yrs.			<b>4. DATE OF DEATH</b> <b>Dec. 21, 1966</b> Month Day Year <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>farming</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Charles W. Bradley, Sr.</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Florence Williamson</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WWII</b> <b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs. Nettie Lord, 5 Merrill Rd.</b> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Myocardial Degeneration</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 2, 1966</b> , <b>to</b> <b>21 Dec, 1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>21 Dec 1966</b> , <b>and that death occurred at</b> <b>3:00 PM</b> , <b>from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>William J. Bryson</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>William J. Bryson</b>				<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <b>4602 Edmonds way Balto. 29 Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE THEREOF</b> <b>Dec. 24, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Grove</b>			
<b>23d. LOCATION (City or Town)</b> <b>Caroline, Md.</b>		<b>(County)</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <b>MOORE FUNERAL HOME, DENTON, MO.</b> ADDRESS				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 28 1966</b> DATE			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16628

16630

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>1yr7mth9dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>6681 Ritchie Road Spur</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Elizabeth</b> Middle <b>Ann</b> Last <b>Brady</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1878</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Adams</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Flowers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerotic cardiovascular heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerosis, generalized</b> (c) <b>Arteriosclerosis, generalized</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 12</b> , 19 <b>65</b> , to <b>Dec. 21</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 21</b> , 19 <b>66</b> , and that death occurred at <b>5:35</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Forestville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 6 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

35021

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16629

CERTIFICATE OF DEATH

16631

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21212</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>30-4</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1006 Woodson Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Peyton BROACH</b>		4. DATE OF DEATH Month Day Year <b>December 9, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1894</b>
9. AGE (In years last birthday) <b>72 43 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Broach</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-1008</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/3/</b> , 19 <b>66</b> , to <b>12/9/</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/9/</b> , 19 <b>66</b> , and that death occurred at <b>3p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Govinda Rao</b>		22b. DATE SIGNED <b>Dec. 9 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Govinda Rao</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Baptist Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>White House, Balto. Co</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16630

16632

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE MERE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGE MERE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>11 W. HICKAM RD.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM R. BROOKS</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/03</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>03</u> Days <u>1</u> Hours <u>00</u> Min. <u>00</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY <u>BETH. SHIP</u>	
12. BIRTHPLACE (State or foreign country) <u>MD</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>ROBERT BROOKS</u>		15. MOTHER'S MAIDEN NAME <u>?</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u>		17. SOCIAL SECURITY NO. <u>213-07-7359</u>	
18. INFORMANT <u>WIFE</u>		Address <u>ABOVE</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause listed. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>00</u> p.m. <u>00</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C. Callus</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>THEO C. Callus</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR <u>J. H. Connolly Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>	
ADDRESS <u>300 Mace</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "REPORT" and "DATE" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16631

## CERTIFICATE OF DEATH

16633

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn - 7</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5617 Prince George ST.</u>		d. STREET ADDRESS <u>Lived and worked at SPRING GROVE HOSPITAL</u>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>J.</u> Last <u>BROWN SR.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 21, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SPRING GROVE HOSP</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL W. BROWN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA WRIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-36-0649</u>	
17. INFORMANT <u>DOROTHY N. BROWN</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse intra-abdominal metastases</u> <u>153.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cecum</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>66</u> , to <u>12-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-2</u> 19 <u>66</u> , and that death occurred at <u>4:00</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>12-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6209 Frederick Ave. Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>FREDERICK CO MD</u>
24. FUNERAL DIRECTOR <u>E.S. MACNABB</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>	
ADDRESS <u>301 FREDERICK RD 21228</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10031

STATE OF DEATH

10031

STATE OF DEATH  
10031



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16632

## CERTIFICATE OF DEATH

16634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>112 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3409 Springdale Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES HUNTER BROWN</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 3 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/37</b>
9. AGE (In years last birthday) yrs. <b>29</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Brown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Hunter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 11/5/62-8/20/64</b>		16. SOCIAL SECURITY NO. <b>212-34-08-00</b>	
17. INFORMANT <b>Clinical Records, VAH, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, UNDETERMINED ORGANISM</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MATASTASES TO PLEURA, LIVER, BONE</b> DUE TO (c) <b>SQUAMOUS CELL CARCINOMA, RIGHT LUNG</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>8/13</b> , 19 <b>66</b> , to <b>12/3</b> , 19 <b>66</b> , that <del>XX</del> (we) last saw the deceased alive on <b>12/3</b> , 19 <b>66</b> , and that death occurred at <b>3:25A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson</i>		22b. DATE SIGNED <b>12 3 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/7/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Nutter Funeral Home, 3035 W. North Ave. Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If possible remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10034

CERTIFICATE OF DEATH

10034

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16633

Item 7 Film G384 12/30/66 mh

CERTIFICATE OF DEATH

16635

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Towson #4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital 7620 York Rd. 21204</b>		d. STREET ADDRESS <b>1316 Stonebridge Ct.</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>BUEDEL</b> Last <b>BUEDEL</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. <del>MARRIED</del> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>7-9-93</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank Buedel</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Link</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown No</b>		16. SOCIAL SECURITY NO. <b>220-44-2432</b>	
17. INFORMANT <b>Niece: Mrs. A. Mueller, 522 Epsom Rd. 2204</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1) Carcinoma of <del>pancreas</del> stomach with metastasis to liver and regional lymph nodes</b> DUE TO (b) <b>2) Pyloric obstruction</b> DUE TO (c) <b>3) Focal hemorrhagic enterocolitis</b> <b>4) Arteriosclerotic Cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(*)</del> (this hospital) attended the deceased from <b>12-15-66</b> , 19 <b>66</b> , to <b>12-25</b> , 19 <b>66</b> that <del>(*)</del> (we) last saw the deceased alive on <b>12-25</b> , 19 <b>66</b> , and that death occurred at <b>10:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Govinda Rao</b>		22b. DATE SIGNED <b>12-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Govinda Rao</b>		22d. ADDRESS <b>7620 York Road, Towson, Maryland 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Link moved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16634											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - ROCKDALE</b> c. LENGTH OF STAY IN ID <b>20 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8208 LIBERTY RD</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - HERBVILLE</b> d. STREET ADDRESS <b>ROLLING RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>EVALEA C BULL</b>			4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1966</b>			5. SEX <b>F</b>			6. COLOR OR RACE <b>W</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>JULY 14, 1899</b>			9. AGE (In years last birthday) <b>67</b> yrs.			IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>14</b> Min. <b>1966</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>			11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM SMITH</b>						14. MOTHER'S MAIDEN NAME <b>HOCHSCHILD</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>						16. SOCIAL SECURITY NO. <b>218-26-57308</b>					
17. INFORMANT <b>HUSBAND - JACOB ALLEN BULL</b>						Address <b>BALTO 21207, MD. 8010 LIBERTY RD</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> 4201 DUE TO <b>GONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO <b>HYPERTENSION</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>3 WEEKS</b> <b>15 YEARS</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1957</b> to <b>Dec 14, 1966</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec 12, 1966</b> , and that death occurred at <b>7:44 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Edwin L. Pierpont</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED <b>DEC 19 1966</b>											
22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>											
22d. ADDRESS <b>8204 LIBERTY RD - BALTO, 21207 MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>											
23b. DATE THEREOF <b>12/17/66</b>											
23c. NAME OF CEMETERY OR CREMATORY <b>Hereford Baptist Church Cemetery</b>											
23d. LOCATION (City, town or county) (State) <b>MD</b>											
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd</b>											
25a. REC'D BY REGISTRAR <b>Charles Judge</b>											
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											
DATE <b>DEC 19 1966</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16635 CERTIFICATE OF DEATH 16637

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>404 E. Penna. ave</u>		e. STREET ADDRESS <u>404 E. Penna. ave</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H</u> Middle <u>Byers</u> Last		4. DATE OF DEATH <u>12/13</u> Month <u>12</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/75</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		9b. AGE (In years last birthday) <u>91</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed B. W. F.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>O.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>O.S.A</u>	
13. FATHER'S NAME <u>unk</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Catharine Byers</u> Address <u>404 E. Penna. ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>SEPT 6</u> , 19 <u>56</u> , to <u>DEC 13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>DEC 11</u> , 19 <u>66</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>T. C. Siwinski</u>		22b. DATE SIGNED <u>Dec. 15, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>		22d. ADDRESS <u>206 W. Penna. Ave., Towson, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		23d. LOCATION (City, town or county) (State) <u>Towson Balto Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Am. L. Chaturvedi</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1966</u>	
ADDRESS <u>1201 M &amp; Aille St Balto. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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Dec. 11, 1900

205 E. Tenth Ave., Denver, Colorado

J. A. Johnston, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16636

CERTIFICATE OF DEATH

16638

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>38yr10mth28dys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>15 Paloma Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Doris</u> Middle <u>E.</u> Last <u>Calder</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Seybold</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Fell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and Shock</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis, chronic, with exacerbation</u> DUE TO (c) <u>Arteriolar nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Heart Disease with RBBB and old diaphragmatic myocardial infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <u>Jan. 7, 1968</u> to <u>Dec. 9, 1966</u> , that (a) (we) last saw the deceased alive on <u>Dec. 9, 1966</u> , and that death occurred at <u>10:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anthony J. Young, M.D.</u>		22b. DATE SIGNED <u>12-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Anthony J. Young, M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Md. 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 12, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>G. Truman Schwab</u>		25a. REC'D BY REGISTRAR <u>DEC 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16637

CERTIFICATE OF DEATH

16639

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth25days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>5815 Skyline Drive</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>S.</b> Last <b>Canhan</b>		4. DATE OF DEATH Month <b>12</b> Day <b>3</b> Year <b>1966</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 11, 1892</b>	9. AGE (In years lost birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>12</b> Days <b>3</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>registered nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Nova Scotia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Burton Sweet</b>		14. MOTHER'S MAIDEN NAME <b>Alice Eaton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Diabetes mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (if this hospital) attended the deceased from <b>Sept. 27, 1966</b> , to <b>12-3</b> , 1966, that (we) lost the deceased alive on <b>12-3</b> , 1966, and that death occurred at <b>2:40 P.M.</b> , from causes on and on the date stated above.					
22a. SIGNATURE <b>Rolando Vieta</b>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>ROLANDO G. VIETA</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b> <b>Baltimore, Maryland 21228</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 6, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Arlington, Va.</b>	
23d. LOCATION (City or Town) <b>Arlington, Va.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Bay J. E. Luthin</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10031

10031

Form with multiple sections and fields, including checkboxes and text areas. The form is oriented vertically and contains various labels and input fields, some of which are partially obscured or faded. The form is divided into several horizontal sections by lines. The top section contains the number '10031' on both the left and right sides. Below this, there are several lines of text and checkboxes. The middle section contains a large, faint, and mostly illegible text area. The bottom section contains a few more lines of text and checkboxes. The form appears to be a standard administrative or reporting form from a past era.

16638

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16638

16640

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXX</del> <b>Baltimore</b> <b>21040</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>3316 Fairview Ave.</b> <del>XXXXXX Edgewood Road</del>	
3. NAME OF DECEASED (Type or print) First <b>Vincent</b> Middle <b>James</b> Last <b>Cannaliato</b> <b>SR</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-05</b>
9. AGE (In years lost birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>30</b> Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pharmacist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Edgewood Arsenal</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Cannaliato</b>		14. MOTHER'S MAIDEN NAME <b>Agnello</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>3316 Fairview Ave.</b>	
17. INFORMANT <b>Concetta A. Cannaliato</b>		<del>XXXXXX Edgewood Road</del>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart failure due to</b> <b>420.1</b> <del>XXXX Old myocardial infarction due to severe coronary</del> <del>XXXX arteriosclerosis</del> <del>XXXX</del> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>Nov. 26</b> , 19 <b>66</b> to <b>Dec. 3</b> , 19 <b>66</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>Dec. 3</b> , 19 <b>66</b> , and that death occurred at <b>12:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i>		22b. DATE SIGNED <b>Dec. 3, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7920 York Road, Towson 4, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-7-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <i>Ellsworth Chmact</i>		25a. REC'D BY REGISTRAR <b>DEC 6 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

14231

932



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16639

## CERTIFICATE OF DEATH

16641

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>86 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30.4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home, Md.</u>				d. STREET ADDRESS <u>5040 Berane Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Francis</u> Last <u>Cantler</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/1878</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John J. Elliot</u>				14. MOTHER'S MAIDEN NAME <u>Annie Clark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Daughter Marie Taylor, 5640 Berane Ave, Balto</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Insufficiency</u> DUE TO <u>450.0</u> (b) <u>Arteriosclerosis</u> DUE TO <u>25 yrs</u> (c) <u>11/22/77</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>25 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infection of left lower leg &amp; foot</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>66</u> , to <u>12/29</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12/29</u> 19 <u>66</u> , and that death occurred at <u>12:58</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>David E. Zickhouse, M.D.</u>				22b. DATE SIGNED <u>12/29/66</u>		22c. PHYSICIAN'S NAME (Type) <u>David E. Zickhouse, M.D.</u>	
22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/31/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Zion Methodist Church Cem. Harford County, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Eugenia K. Seitz 5209 York Road, Balto. Md. 21202</u>				25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14331

RECEIVED OF DEATH

1983

RECEIVED OF DEATH  
1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16640

CERTIFICATE OF DEATH

16642

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr9mth22dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant, Maryland</b>		16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>604 - 63rd Place</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>R.</b> Last <b>Carrick</b>		4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1890</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Clem Lovelass</b>		14. MOTHER'S MAIDEN NAME <b>Cora Nalley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>493X PNEUMONIA</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic cardiovascular Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>Jan. 9, 19 64</b> to <b>Dec. 20, 19 66</b> that (H) (we) last saw the deceased alive on <b>Dec. 20, 19 66</b> , and that death occurred at <b>8:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>12-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Scoschi Sons Hyattsville, Md</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>			

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RECORDS OF CLAIMS

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE HEALTH DEPT.

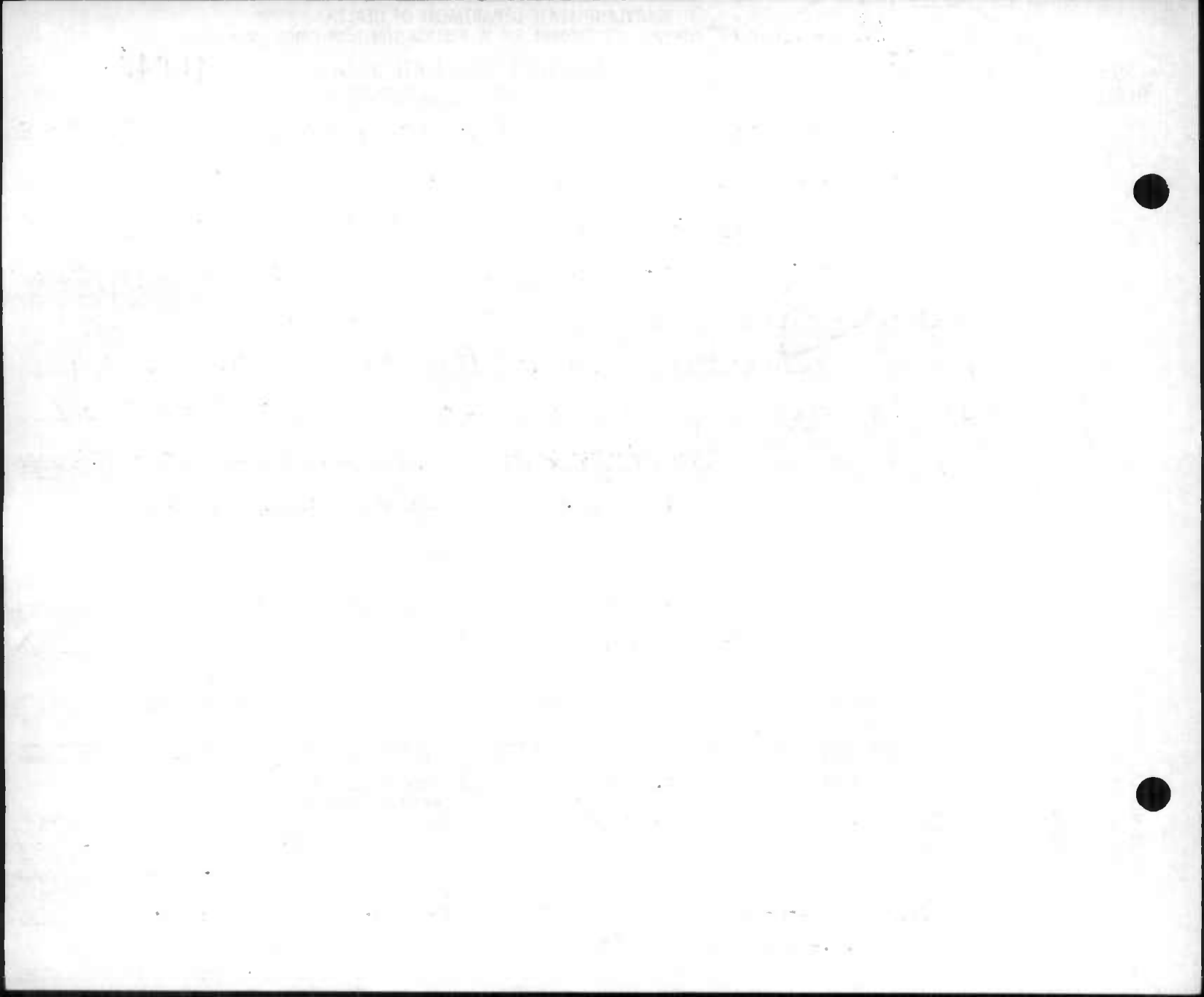
16641

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16643

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>9YR</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE 03.1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5904 PRINCE GEORGE ST</b>			d. STREET ADDRESS <b>5904 PRINCE GEORGE ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES ANTHONY CASCIO</b>			4. DATE OF DEATH Month Day Year <b>DEC 31, 1966</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 4, 1924</b>		9. AGE (In years last birthday) yrs. <b>42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BALTD TRANSIT CO</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSPORTATION</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>LISA</b>			13. FATHER'S NAME <b>JOSEPH ANTHONY CASCIO</b>		
14. MOTHER'S MAIDEN NAME <b>JOSEPHINE DANTONI</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES -</b>		
16. SOCIAL SECURITY NO. <b>218-14-4696</b>			17. INFORMANT Address <b>MRS JOSEPHINE CASCIO-SAME ADDRESS</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GASTRIC ULCER</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John N. Snyder</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>1/2/67</b>	
EXAMINER'S NAME (Type) <b>JOHN N. SNYDER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>6348 FREDERICK</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Witzke F.D.-4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16642

CERTIFICATE OF DEATH

16644

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN 1b <b>172 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3003 Glendale Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>JOSEPH</b> Last <b>CASEY</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>26</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/18/06</b>	
9. AGE (In years last birthday) yrs. <b>60</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York City, New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>William J. Casey</b>			
14. MOTHER'S MAIDEN NAME <b>Mary I. Daley</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>			
16. SOCIAL SECURITY NO. <b>082-09-61-48</b>				17. INFORMANT Address <b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF RIGHT LUNG WITH METASTASIS TO BRAIN</b> <b>163X</b> <del>XXXX</del> AND LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>July 7, 1966</b> to <b>Dec. 26, 1966</b> , that (X) (we) last saw the deceased alive on <b>Dec. 26, 1966</b> , and that death occurred at <b>1:25 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Jorge A. Fabara</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12 27 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>				22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-29-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Maryland</b>	
24. FUNERAL DIRECTOR <b>ZANNINO FUNERAL HOME</b>				ADDRESS <b>257 S. Conkling, Baltimore</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16643

## CERTIFICATE OF DEATH

16645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1403 Carswell St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret T. Cashman</u>		<b>4. DATE OF DEATH</b> <u>Dec. 5 19 66</u>		<b>5. SEX</b> <u>Female</u>			
<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Feb. 25, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>84 yrs.</u> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk-Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bond Baking Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Michael</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Shehan</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-01-6468</u>		<b>17. INFORMANT</b> <u>Self (from record)</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (b) <u>Senility</u> (a), stating the underlying cause last. (c)				INTERVAL BETWEEN ONSET AND DEATH <u>Approx 3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 11, 1960</u> <b>to</b> <u>Dec 5, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Dec 3, 1966</u> , <b>and that death occurred at</b> <u>10pm</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert J. Mahon</u>		<b>22b. DATE SIGNED</b> <u>12/5/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert J. Mahon, M.D.</u>			
<b>22d. ADDRESS</b> <u>1402 204 E. Joppa Road, Towson, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>12/9/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral</u>			
<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.W. Jenkins &amp; Sons Co.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 6 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

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1. PLACE OF DEATH a. COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manor Rd.</u>		d. STREET ADDRESS <u>Manor Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>Polston</u> Last <u>CASTERLOW</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1964</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13, 1900</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Shoe. Polston</u>		14. MOTHER'S MAIDEN NAME <u>Georganna Gardon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-32-2466</u>	
17. INFORMANT <u>Charlotte Cook - Glenarm, md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Trans. Stokes Adams Syndrome with Convulsions</u> DUE TO <u>Heart Block</u> (b) <u>Mitral Regurgitation</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(11-8-66 to 11-21-66 in Johns Hopkins Hospital for chg)</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs +</u> <u>2 yrs +</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-10-1964</u> to <u>Dec 5, 1966</u> that (I) (we) last saw the deceased alive on <u>11-7-1966</u> and that death occurred at <u>11 p. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Isabel H. McClellan</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Chatman Jr.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE	

1864

CERTIFICATE OF DEATH

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DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16645

Item 2 Film G384 1/4/67 mh

## CERTIFICATE OF DEATH

16647

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> <u>Catoesville Md.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Catoesville</u> <u>315 Ingleside Ave</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>21217</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Forest Haven Nursing Home Inc.</u>		d. STREET ADDRESS <u>2401 Eutaw Place</u> <u>315 Ingleside Ave</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH CATALFAMO</u>		4. DATE OF DEATH <u>Dec. 26 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 19 1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not Known</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gioachino Catalfamo</u>		14. MOTHER'S MAIDEN NAME <u>Antonina ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-12-0830</u>	
17. INFORMANT <u>Mr. John Christenson Bowie Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA (acute)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROTIC CHANGES - VASCULAR</u> DUE TO (c) <u>DIABETES</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>66</u> , to <u>12/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>66</u> , and that death occurred at <u>4 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Sharkey</u>		22b. DATE SIGNED <u>12/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Sharkey</u>		22d. ADDRESS <u>828 E. Lombard Ave. Bal. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 29 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>4430 Belair Rd. Bal. Md.</u>
24. FUNERAL DIRECTOR <u>Frank Della Noce</u>		25. REC'D BY REGISTRAR DATE <u>DEC 29 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16648

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shipping Place Park</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b> d. STREET ADDRESS <b>110 Baltimore Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT (nmn) CHANNELL, Sr.</b>		4. DATE OF DEATH <b>December 30, 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4, 1892</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George W. Channell</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth E. Ferry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-30-1552</b>	
17. INFORMANT <b>Madeline S. Channell, Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V- Disease</b> <b>420.1</b> OUE TO (b) <b>(Coronary Occlusion)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of Injury in Part I or Part II of Item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M B Davis</b>		22. DATE SIGNED <b>12/31/66</b>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Dundalk, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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REGION: EXAMINER CERTIFICATE OF DEATH

FOR TYPE

DEATH OF

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16647

CERTIFICATE OF DEATH

16649

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowleys Quarters</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clark's Point Road</u>		d. STREET ADDRESS <u>Clark's Point Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emmett</u> Middle <u>R.</u> Last <u>Charles, Sr.</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>19 66</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1905</u>
9. AGE (In years lost birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Anglemith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship-Building</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMMETT R. CHARLES</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bertha C. Charles</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>66</u> to <u>12/16</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>66</u> , and that death occurred at <u>2:50p</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Albert J. Himelfarb</u>		22b. DATE SIGNED <u>12/16/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J. HIMELFARB</u>		22d. ADDRESS <u>3501 ST. PAUL ST BALTO Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. RECEIVED BY REGISTRAR <u>DEC 19 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10041

10041

THIS IS A COPY OF THE ORIGINAL RECORD OF THE  
FEDERAL BUREAU OF INVESTIGATION  
AND IS NOT TO BE USED FOR ANY OTHER PURPOSE  
EXCEPT AS A REFERENCE TO THE ORIGINAL RECORD  
IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS  
ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM  
WITHOUT THE WRITTEN PERMISSION OF THE DIRECTOR, FBI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16648

## CERTIFICATE OF DEATH

16650

1. PLACE OF DEATH o. COUNTY <b>BALTO</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
<b>Balto. County</b>				<b>1815 Forest Park Ave</b>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>George</b> Middle <b>T.</b> Last <b>Chenoweth</b>				Month <b>12</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/8-1882</b>	
				9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County Md.</b>			
13. FATHER'S NAME <b>George Chenoweth</b>				14. MOTHER'S MAIDEN NAME <b>Meyers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-01-0178</b>			
				17. INFORMANT <b>Tunie Chenoweth</b> Address <b>4815 Forest Park Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> <b>3 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>Kimberly V. Patterson</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Balto. County Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<b>Burial</b>		<b>12-28-66</b>		<b>Lorraine Cemetery</b>		<b>Balto. Maryland</b>	
24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>				ADDRESS <b>4600 Liberty Heights Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13662

STATE OF TEXAS

10880

13662

STATE OF TEXAS

10880



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16649

## CERTIFICATE OF DEATH

16651

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>45yr6mth28dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> <u>13-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>EDWARD</u> Last <u>Chilcoat</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1893</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis E. Chilcoat</u>				14. MOTHER'S MAIDEN NAME <u>E. Elizabeth Wheeler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>219-54-3066</u>		17. INFORMANT <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Rheumatic heart disease with mitral insufficiency</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <u>  </u> at work <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>61</u> , to <u>Dec. 6</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>Dec. 6</u> , 19 <u>66</u> , and that death occurred at <u>11:40</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u>				a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u>				22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Md. 21228</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bosley Church Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Sparks Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons</u>				25a. REC'D BY REGISTRAR <u>DEC 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



18001

UNITED STATES OF AMERICA

18001

18001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16650					16652				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <b>Baltimore</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>					b. COUNTY <b>Baltimore</b>				
c. LENGTH OF STAY IN 1b <b>Woodlawn</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>0311</b>				
d. STREET ADDRESS <b>5425 Lewellen Ave. 7</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Clara B. Clark</b>					4. DATE OF DEATH <b>Month Day Year</b> <b>December 25, 1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1881</b>		9. AGE (In years last birthday) <b>85 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Sales Lady</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>Andrew Ensor</b>					14. MOTHER'S MAIDEN NAME <b>Alice V. Grove</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Ensor A. Clark</b>		18. ADDRESS <b>5508 Windsor Mill Road Baltimore, Md. 21207</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Serulity</b>								INTERVAL BETWEEN ONSET AND DEATH <b>15 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/25/1966</b> , to <b>12/25/1966</b> , that (I) (we) last saw the deceased alive on <b>12/25/1966</b> , and that death occurred at <b>11:00</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Wm. E. Martin</b>					22b. DATE SIGNED <b>12/25/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Wm. E. Martin</b>					22d. ADDRESS <b>Randallstown Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. J. Tinkler &amp; Sons</b>					25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>				

07321

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**16651**

**CERTIFICATE OF DEATH**

**16653**

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore WOODLAWN</b>			c. LENGTH OF STAY IN lb <b>03.1</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore WOODLAWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2108 Thistlebloom Road</b>				d. STREET ADDRESS <b>2108 Thistlebloom Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ODESSA E. CLAYTON</b>				4. DATE OF DEATH Month Day Year <b>December 23, 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-1885</b>		9. AGE (In years last birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Clayton</b>				14. MOTHER'S MAIDEN NAME <b>Amelia M.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Myra Beitler, 2108 Thistlebloom Rd. 21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congestive heart failure, Chronic</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour am p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 59</b> to <b>Dec 23, 19 66</b> that (I) (we) last saw the deceased alive on <b>12-23</b> 19 <b>66</b> , and that death occurred at <b>10:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Christian S. Mass</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Christian S. Mass</b>				22d. ADDRESS <b>Baltimore National Pike &amp; ST. Johns La</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-27-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>3801 Frederick Ave. Balto. Md</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

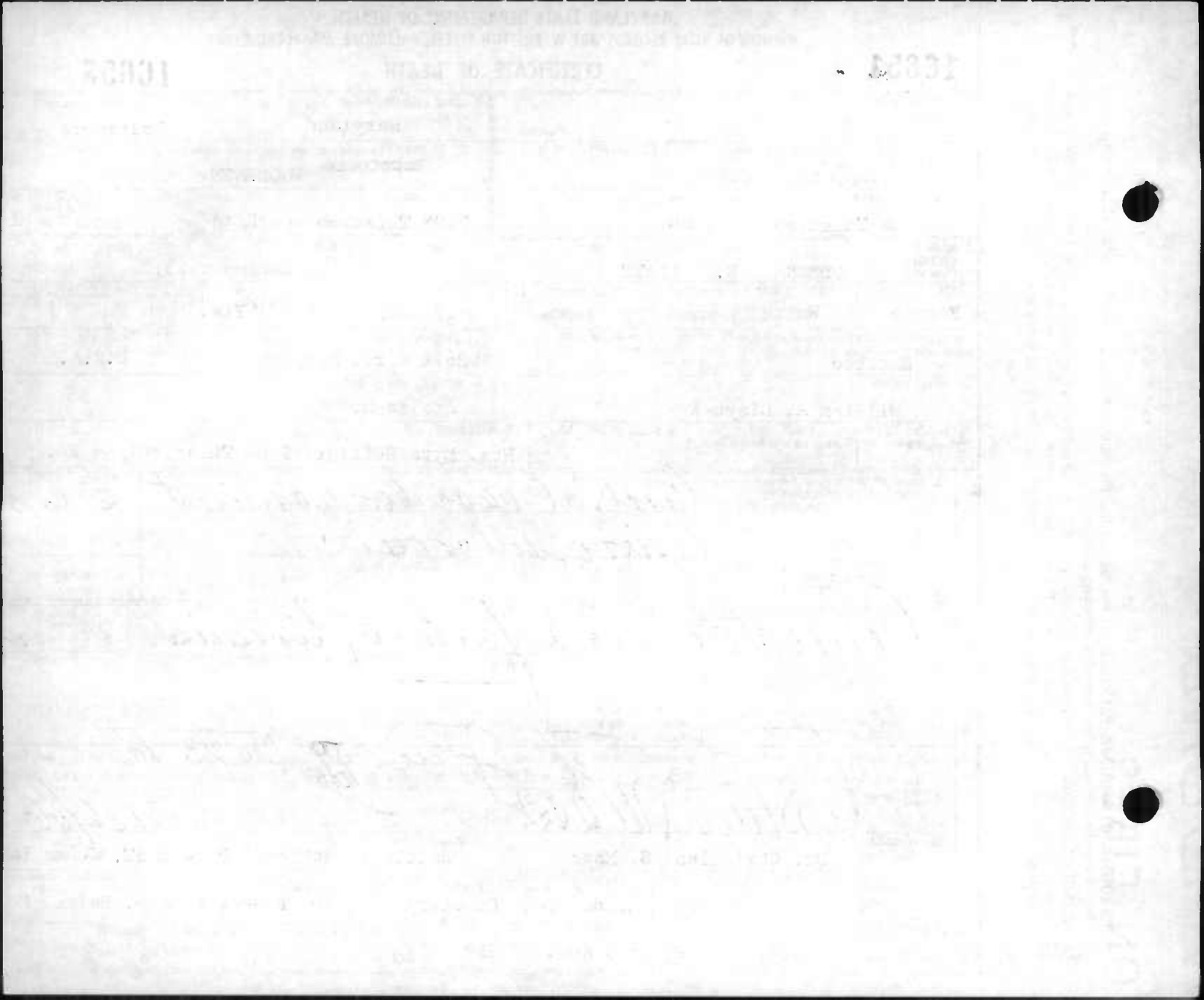
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body, in any event, within 72 hours after death.

10032

OFFICE OF THE

10032



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills,</u> c. LENGTH OF STAY IN 1b <u>8½ yrs.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>Box 405 - Rt. I</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ralph Sidney COATES</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>13</u> Year <u>19 66</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 10, 1954</u>		<b>9. AGE</b> (In years last birthday) <u>12</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Severna Park, Md.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>								
<b>13. FATHER'S NAME</b> <u>Robert Coates</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>DAY, Marceline</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> <u>Address</u>		<u>Rosewood Records, Owings Mills, Md.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Multiple Pulmonary Abscesses</u> <u>521X</u> DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <u>Neuroticizing Bronchopneumonia</u> <b>(c)</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Months</u> <u>Days</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/23, 1958</u> , to <u>12/13, 1966</u> , that (I) (we) last saw the deceased alive on <u>12/13/66</u> 19 <u>66</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Zsolt Koppanyi</u>						<b>22b. DATE SIGNED</b> <u>12/13/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Zsolt Koppanyi, M.D.</u>									
<b>22d. ADDRESS</b> <u>Rosewood State Hosp., Owings Mills, Md.</u>						<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22f. ATTENDING PHYS.</b> <input type="checkbox"/>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>12/17/66</u>				<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Carpenter Cemetery, Jones Station, Md.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Severna Park, Md.</u>									
<b>24. FUNERAL DIRECTOR</b> <u>John B. Johnson Jr.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 19 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>									

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DEPARTMENT OF HEALTH

10000

Boyle  
Hunt

Memorandum of Understanding  
between the Department of Health  
and the Department of Education

W. H. H. H.  
12/13/60

12/13/60

12/13/60



CERTIFICATE OF DEATH

16653

16655

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN lb <b>8 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY P. COHEN</b>		4. DATE OF DEATH <b>December 17, 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 17, 1897</b> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocery</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DAVID COHEN</b>		14. MOTHER'S MAIDEN NAME <b>Miriam ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Sadie Cohen</b> Address <b>WIFE - 2623 W. BELVEDERE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>153.8</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE</b> DUE TO <b>COLON</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 YEARS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12.9</b> , 19 <b>66</b> , to <b>12.17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12.17</b> , 19 <b>66</b> , and that death occurred at <b>3A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Quintin L. Uy</b>		22b. DATE SIGNED <b>12.17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>QUINTIN L. UY</b>		22d. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/18/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adath Jeshurun</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Francis Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ESTIMATE OF CASH

10055

NAME		DATE	
ADDRESS		CITY	
STATE		COUNTY	
ZIP		FEDERAL RESERVE	
BANK		BRANCH	
ACCOUNT		TYPE	
BALANCE		INTEREST	
TOTAL		PERCENT	
DATE		TIME	
SIGNATURE		INITIALS	
PRINTED NAME		PRINTED ADDRESS	
PRINTED CITY		PRINTED STATE	
PRINTED ZIP		PRINTED COUNTY	
PRINTED FEDERAL RESERVE		PRINTED BANK	
PRINTED BRANCH		PRINTED ACCOUNT	
PRINTED BALANCE		PRINTED INTEREST	
PRINTED TOTAL		PRINTED PERCENT	
PRINTED DATE		PRINTED TIME	
PRINTED SIGNATURE		PRINTED INITIALS	
PRINTED PRINTED NAME		PRINTED PRINTED ADDRESS	
PRINTED PRINTED CITY		PRINTED PRINTED STATE	
PRINTED PRINTED ZIP		PRINTED PRINTED COUNTY	
PRINTED PRINTED FEDERAL RESERVE		PRINTED PRINTED BANK	
PRINTED PRINTED BRANCH		PRINTED PRINTED ACCOUNT	
PRINTED PRINTED BALANCE		PRINTED PRINTED INTEREST	
PRINTED PRINTED TOTAL		PRINTED PRINTED PERCENT	
PRINTED PRINTED DATE		PRINTED PRINTED TIME	
PRINTED PRINTED SIGNATURE		PRINTED PRINTED INITIALS	

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16654

## CERTIFICATE OF DEATH

16656

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Maryland</b> b. COUNTY <b>Charles County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>7 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>Bryans Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Ann</b> Last <b>Cole</b>				4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-27-52</b>		9. AGE (In years last birthday) <b>14</b> Yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>George Oscar Cole</b>				14. MOTHER'S MAIDEN NAME <b>Florence Edna Baker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>Medical Records</b> Address <b>Rosewood State Hospital</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Suspected Cerebral-Vascular Accident</b> DUE TO (b) <b>Unknown Cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/20</b> , 19 <b>66</b> , to <b>12/20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/20</b> , 19 <b>66</b> , and that death occurred at <b>8:30</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Philip Zieve</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip Zieve, M.D.</b>				22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles</b>		23d. LOCATION (City or Town) (County) (State) <b>Glymont, Charles Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Archant Funeral Home Inc., La Plata, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF CALIFORNIA

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STATE OF CALIFORNIA  
COUNTY OF ...  
IN SENATE  
January 1, 1908  
REPORT OF THE  
COMMISSIONERS OF THE  
LAND COMMISSION  
TO THE SENATE  
FOR THE YEAR  
1907  
PUBLISHED BY THE  
STATE PRINTING OFFICE  
1908

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

16655  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
16657

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
c. LENGTH OF STAY IN 1b <b>38 years</b>		d. STREET ADDRESS <b>11 Flagship Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11 Flagship Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BARTLEY DEMPSEY COLEMAN</b>		4. DATE OF DEATH <b>December 28th 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Nov. 23, 1888</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Adjustor (Wire)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mfr.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Herbert Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Ada Kearney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-9900A</b>	
17. INFORMANT <b>Helen O. Burke, same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V- Disease</b> <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO (b) <b>Senility</b> OUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Maryland</b>	
22. DATE SIGNED <b>12/29/66</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/31/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		OATE	

10055

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-10

THE CITY

DEATH NO.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16656

## CERTIFICATE OF DEATH

16658

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>305 SOUTH CLINTON STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS XAVIER CONNIFF</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 5, 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 27 14</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATIONARY ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEAT PACKING PLANT BALTIMORE, MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK CONNIFF</b>		14. MOTHER'S MAIDEN NAME <b>THERESA McAVOY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes give war or dates of service) <b>YES WW-11</b>		16. SOCIAL SECURITY NO. <b>219 01 06 67</b>	
17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE SCLEROSIS. ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>17</b> (this hospital) attended the deceased from <b>NOV. 29</b> , 1966, to <b>DEC. 5</b> , 1966, that <b>17</b> (we) last saw the deceased alive on <b>DEC. 5</b> , 1966, and that death occurred at <b>12:35</b> P. M. from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Tuller</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>VET. ADM. HOSP., FT. HOWARD, MD.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, or other final disposition (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/9/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Zannino Funeral Home</b> <b>263 S. Conkling St.</b> <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16657

## CERTIFICATE OF DEATH

16659

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN 1b <u>36 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTIMORE COUNTY HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> d. STREET ADDRESS <u>5303 WINDSOR MILL RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOHN</u> First Middle Last <u>C. CONNOLLY</u> <b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>6</u> Year <u>1966</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/29/1892</u> <b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired- Painter</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Self- Empl.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John T. Connolly</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>218.03.4442.A</u> <b>17. INFORMANT</b> <u>Louise M. Connolly</u> Address <u>Same as # 2</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> (b) <u>BRONCHOGENIC CARCINOMA J ASHD</u> (c) <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. _____ <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____		<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>11-1-66</u> , 19 <u>12-6-66</u> , that (I) (we) last saw the deceased alive on <u>12-6-66</u> , 19_____, and that death occurred at <u>4:41 A</u> M, from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>Dr. Milton Sclenoff</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>MILTON SCLENOFF</u> <b>22b. DATE SIGNED</b> <u>12-6-66</u> <b>22d. ADDRESS</b> <u>BALTIMORE COUNTY HOSPITAL</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>12/9/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Wards Chaple</u> <b>23d. LOCATION</b> (City, town or county) <u>Baltimore County Md.</u> (State) _____		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J.T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u> <b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 8</u> 1966 <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

13557

CERTIFICATE OF DEATH

18853

BALTIMORE

AND

BALTIMORE

RAPPAHANNOCK

30 DAYS

30 DAYS

BALTIMORE COUNTY RAPPANNOCK MIDDLE

JOHN

CONWAY

4-1

MALE WHITE

1811/187

77

Resident - Baltimore

Belt - 34 1/2

Baltimore Md.

John T. Connolly

John Connolly

NO 10

John T. Connolly, Baltimore, Md.

Completed March 1885

Resident - Baltimore

John T. Connolly

Baltimore County, Md.

John T. Connolly

John T. Connolly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16658

## CERTIFICATE OF DEATH

16660

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>1125 Ramblewood Rd Apt 304</u>	
3. NAME OF DECEASED (Type or print) <u>Kathryn Whittle Considine</u>		4. DATE OF DEATH <u>12 8 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife - Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St Michael, Md</u>	
13. FATHER'S NAME <u>Edward Whittle (Dec)</u>		14. MOTHER'S MAIDEN NAME <u>McDonald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214 228557</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic carcinoma</u> (c) <u>Carcinoma of breast</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-26</u> , 19 <u>66</u> , to <u>12-8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-8</u> 19 <u>66</u> , and that death occurred at <u>1:40</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. W. Smith</u>		22b. DATE SIGNED <u>12-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. W. Smith</u>		22d. ADDRESS <u>Greater Baltimore Med. Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/10/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1905 York Road Balto. 12, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 12 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

16659

16661

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore,</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jutherville,</u> <span style="float: right;">03.1</span> d. STREET ADDRESS <u>1113 Long Creek Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Edna</u> Middle <u>Marie</u> Last <u>Creamer</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>5</u> Year <u>1966</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-22-19</u>		<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Office Clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>City Of Balto.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.G.</u>					
<b>13. FATHER'S NAME</b> <u>Martin L. Miller.</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Edna Hanna.</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>216-07-1382</u>		<b>17. INFORMANT</b> <u>Mr. Frederick W. Creamer</u>				Address <u>(Same)</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONSOLIDATED LOBULAR</u> 491X DUE TO (b) <u>PNEUMONIA - ETIOLOGY UNDETER.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>MINIED - ? VIRAL</u>										INTERVAL BETWEEN ONSET AND DEATH <u>45 DAYS</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 26, 1966</u> , <b>to</b> <u>Dec 5, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec. 5, 1966</u> , <b>and that death occurred at</b> <u>9<sup>43</sup> PM</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Duwlisky</u>								<b>22b. DATE SIGNED</b> <u>12-5-66</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dora C. Kuwilsky</u>						<b>22d. ADDRESS</b> <u>Greater Baltimore Medical Center</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/9/66.</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 7 1966</u>						<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

MEDICAL CERTIFICATION



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Office Clerk

City Clerk

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16660

CERTIFICATE OF DEATH

16662

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>College Manor</u> <u>Lutherville</u> <u>Md.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor</u>		d. STREET ADDRESS <u>Marlborough Apts.</u> <u>Wilson &amp; Eutaw Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>A.</u> Last <u>Crow</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1879</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arizona</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Arizona</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John S. Armstrong</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Finch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-4695</u>	
17. INFORMANT <u>John A. Crow</u>		Address <u>Rock Hill, S.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular Failure</u> DUE TO <u>Cerebrovascular Disease</u> (b) <u>Myocardial Infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24-36 hrs</u> <u>11</u> <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 28</u> , 19 <u>65</u> , to <u>Dec 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 31</u> , 19 <u>66</u> , and that death occurred at <u>6:59</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>W H Wooley</u>		22b. DATE SIGNED <u>12-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W H Wooley</u>		22d. ADDRESS <u>1403 Park Ave Baltimore Md 21212</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

50301

92321

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16661

16663

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST POINT</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LFM STORE ON EASTERN AVE</u>				d. STREET ADDRESS <u>121 EASTERN BLVD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST H. CRUSSE</u>				4. DATE OF DEATH Month Day Year <u>DEC 17 1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>AUG 4 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN CRUSSE</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>213-09-2500</u>		17. INFORMANT <u>WIFE</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-DISEASE</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>12/20/66</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD-6800</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR <u>CONNELLY SONS</u>				ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 23 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10001

THE UNIVERSITY OF CHICAGO

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16664

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			c. LENGTH OF STAY IN 1b <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 1931 Guy Way</b>				d. STREET ADDRESS <b>1931 Guy Way 21222</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>P.</b> Last <b>Cullum Sr.</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 19- 1916</b>	9. AGE (In years last birthday) yrs. <b>50</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>White Coffee Pot. Restaurants</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Cullum</b>				14. MOTHER'S MAIDEN NAME <b>Florence Dougherty</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-12-0144</b>		17. INFORMANT Address <b>Mrs. Henrietta Cullum, 7415 Holabird Ave. Dundalk, Md. 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>12-12-1966</b>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, City, Town, or County) <b>6800 Mornington Rd. Dundalk, Md. 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>			c. LENGTH OF STAY IN 1b <u>9 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>30-4</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BALTIMORE COUNTY General Hosp.</u>					d. STREET ADDRESS <u>3704 W. Belvedere Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose</u>			First <u>Rose</u> Middle <u>NM2</u> Last <u>DANIELS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/5/85</u>		9. AGE (In years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL HERMANN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-12-4913</u>		17. INFORMANT <u>JOHN C. GILL</u>		Address <u>(SAME)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Rt. with abscess</u> <u>154X</u> DUE TO (b) <u>pulmonary embolism</u> DUE TO (c) <u>CA 7 metastasizing with peritoneal</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Kolman de Juy</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-31-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Bulto. County Gen. Hosp.</u>					22d. ADDRESS <u>Bulto. County Gen. Hosp.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEM.</u>		23d. LOCATION (City, town or county) (State) <u>CARROLL CO.</u>			
24. FUNERAL DIRECTOR <u>Paul E. Church</u>					ADDRESS <u>3617 Chestnut Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16666

16666

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>215 B Rodgers Forge Rd. 21212</b>			
3. NAME OF DECEASED (Type or print) First <b>J.</b> Middle <b>Arthur</b> Last <b>DeHoff Sr.</b>				4. DATE OF DEATH Month <b>12</b> Day <b>14</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/94</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jacob T. DeHoff</b>				14. MOTHER'S MAIDEN NAME <b>Ida Bixler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Corinne M. DeHoff same address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/24</b> , 1966, to <b>12/14</b> , 1966, that (I) (we) last saw the deceased alive on <b>12/14</b> , 1966, and that death occurred at <b>8:45 p.m.</b> from causes on and on the date stated above.							
22a. SIGNATURE <b>Ranion P. Lopez</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ranion P Lopez</b>				22d. ADDRESS <b>St. Joseph Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Fickner &amp; Sons</b>				ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

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James F. Wynn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**16663**

**16667**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>			c. LENGTH OF STAY IN 1b <b>5 mo 23 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 16,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				d. STREET ADDRESS <b>2805 Wmchester St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>James</b> Middle <b>DeLoatch</b> Last <b>DeLoatch</b>				<b>4. DATE OF DEATH</b> Month <b>12</b> Day <b>17</b> Year <b>1966</b>			
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>C</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9.10.96</b>	
<b>9. AGE</b> (In years last birthday) <b>70</b> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>N. Carolina</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>William DeLoatch</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <b>213014242</b>		<b>17. INFORMANT</b> <b>Records, Mt. Wilson State Hospital</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tbc.</b> (b) _____ (c) _____ Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 mo.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury In Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>6/24/1966</b> , <b>to</b> <b>12/17/1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>12/17/1966</b> , <b>and that death occurred at</b> <b>12/17/1966</b> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Wm. Newcomer</b>				<b>22b. DATE SIGNED</b> <b>12/17/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>	
<b>22d. ADDRESS</b> <b>Mount Wilson, Maryland</b>				<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12-21-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Baltimore Nat'l. Cem</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Baltimore, Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>George G. Kelson 1348 N. Calhoun St.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 20 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>	

MEDICAL CERTIFICATION

15583

15583

Salisbury County

Mount Wilson

Mount Wilson State Hospital

Records, Mount Wilson State Hospital

Mr. Newcomer, N. D., Superintendent, Mount Wilson, Maryland

VR A1S (4)  
15M 9/S9

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 6</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 6</u>		03-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7902 Montrose Avenue</u>				d. STREET ADDRESS <u>7902 Montrose Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vernon</u>		First <u>J.</u>		Middle <u>Demback</u>		Last	
4. DATE OF DEATH Month <u>Dec.</u>		Day <u>17,</u>		Year <u>19 66</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>2/17/12</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metallurgist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co. Baltimore, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Demback</u>				14. MOTHER'S MAIDEN NAME <u>Helen Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW17</u>		17. INFORMANT <u>Mrs. Norman Walls 7902 Montrose Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic acidosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>44 hrs</u> <u>15 years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 10, 1966</u> to <u>Dec. 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug. 27, 1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R Donald Jandorf</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-12-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		22d. ADDRESS <u>6077 Harford Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore, Maryland</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>		25a. REC'D BY REGISTRAR <u>DEC 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10007

CERTIFICATE OF DEATH

35351

COMMISSIONER OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2  
16667  
16669

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>5 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINISTER</u> <u>MD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FOREST HAVEN CONVALESCENT HOME 226 E. MAIN ST.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RACHEL HELENA DEVILBISS</u>				4. DATE OF DEATH Month Day Year <u>DEC. 28 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 9, 1872</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL WAREHEIM</u>				14. MOTHER'S MAIDEN NAME <u>HELENA SCHAEFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>SYLVIA GILL 1185 GRANVILLE RD. 7.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>MYO CARDIAC INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. } DUE TO (b) <u>MYO CARDIAC INFARCTION</u> DUE TO (c) <u>DISEASE - CHRONIC HEART SYNDROME</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> 19 <u>66</u> , to <u>12/28</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>66</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Snow M.D.</u>				22d. ADDRESS <u>5800 S. GERMANTOWN RD. BALV. 28, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-31-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>TRYLERS</u>		23d. LOCATION (City, town, or county) (State) <u>CARROLL County MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Smith</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

RECEIVED IN DEATH

10000

10000

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. Some words like "received" and "in death" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16668 CERTIFICATE OF DEATH 16670

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>40 days</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Seminary Ave 03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>West Seminary Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William Adam Deyens</u>		4. DATE OF DEATH <u>12 22 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-09</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR <u>57</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care taker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Lutherville - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Elsworth Deyens</u>		14. MOTHER'S MAIDEN NAME <u>Kerchner, Maggie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertensive cardio-vascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Atrial Thrombosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> , 19 <u>66</u> , to <u>Dec 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 22nd</u> , 19 <u>66</u> , and that death occurred at <u>1040 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M. I. Mac Gregor</u>		22b. DATE SIGNED <u>Dec 22-1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GREGOR</u>		22d. ADDRESS <u>Greater Baltimore Med. Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 24, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Falls rd, Balto, Md</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11301

2501

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13, 14 Film G384 1/5/67 mn

16669

## CERTIFICATE OF DEATH

16671

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr2mth14dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle Last <b>Dixon</b>		4. DATE OF DEATH Month <b>12-</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-91</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>219-54-3093-T</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>10-7-65</b> , 19__, to <b>12/25, 1966</b> that (1) (we) lost saw the deceased alive on ____, 19__, and that death occurred at ____, M, from causes on and on the date stated above.			
22a. SIGNATURE <b>A Jaheri</b>		22b. DATE SIGNED <b>12/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Amanollah Jaheri</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Geo L Kelson</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.)

16831

RECEIVED OF DEPT.

3608

TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D.C.

FROM THE COMMISSIONER, BUREAU OF REVENUE, WASHINGTON, D.C.

ST-2-17-1 RECEIVED: BUREAU OF REVENUE, WASHINGTON, D.C.

RECEIVED BY THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D.C.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16670

16672

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>MD</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>STELLA MARIS HOSPICE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>4301 ROLAND AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE D DODSON</b>		4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-1876</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b>	11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MT. HOLLY SPRINGS Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>SIDNEY KEMPTON</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA MUNDORF</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>215-03-3954D</b>	
17. INFORMANT <b>SELF</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4221 CVA</b> DUE TO Conditions, if any, which gave rise to immediate cause } <b>Not</b> (a), stating the underlying cause last. } DUE TO (c) <b>Fracture of Hip</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hrs</b> <b>10 yrs</b> <b>2 Months Ago</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between onset and death	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-25-66</b> , 19... to <b>12-13-66</b> , 1966, that (I) (we) last saw the deceased alive on <b>12-10-66</b> , 1966, and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Mahon</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT MAHON</b>		22d. ADDRESS <b>301 E. Joppa Rd. Towson 4 Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke F. D.</b>		25a. REC'D BY REGISTRAR <b>DEC 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>		25c. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.



*[Faint handwritten notes]*

57301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>21 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Res., 3307 Sollers Point Road</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>3307 Sollers Point Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>CYRUS J. DONNELLY</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>July 4-1893</b> <b>9. AGE (in years last birthday)</b> <b>73</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired, Machinist, Bethlehem Steel Co.</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>						<b>4. DATE OF DEATH</b> <b>Dec. 28-1966</b> <b>19</b> Month Day Year <b>13. FATHER'S NAME</b> <b>Howard Donnelly</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Moore</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes, Army 1912</b> <b>16. SOCIAL SECURITY NO.</b> <b>217-01-1759</b> <b>17. INFORMANT</b> <b>Wife, Mrs. Carrie Donnelly, #2, a, b, c, d.</b> Address													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C. V. Disease</b> <b>4221</b> DUE TO (b) <b>Cerebral Thrombosis left hemisphere</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Decubitus ulcer left buttock</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>640</b> <b>4XR</b> <b>640</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>While</b> <input type="checkbox"/> <b>Not While</b> <input type="checkbox"/> Hour a.m. p.m. at work at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 8, 1966</b> <b>to</b> <b>Dec 28, 1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 28, 1966</b> , <b>and that death occurred at</b> <b>6:30 M.</b> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <b>Stephen C. Mackowiak</b> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Stephen C. Mackowiak M.D.</b> <b>22d. ADDRESS</b> <b>6714 Holabird Ave. Baltimore, Md. 212</b> <b>22b. DATE SIGNED</b> <b>Dec. 29-1966</b>													
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>Dec. 31-1966</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Burns Hill</b> <b>23d. LOCATION (City, town or county) (State)</b> <b>Waynesboro, Pennsylvania</b>													
<b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>JOHN J. DUDA, Dundalk, Maryland 21222</b> <b>DATE</b> <b>JAN 3 1967</b> <b>Charles Judge</b>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

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16672

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16674

1. PLACE OF DEATH a. CDUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forrest Haven Nursing Home</u>				d. STREET ADDRESS <u>3002 Beverly Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Helene</u> Middle <u>Dorsey</u> Last <u>Dorsey</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>19 66</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1911.</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Charles W. Hayward</u>				14. MOTHER'S MAIDEN NAME <u>Suella Gardner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>Mrs. Delmont Lochbaum</u> Address <u>(Same)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Coronary</u> DUE TO (c) <u>Atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>66</u> , to <u>12/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/9</u> 19 <u>66</u> , and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>John H. Shaw</u>				22b. DATE SIGNED <u>12/9/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				22d. ADDRESS <u>5804 Edmonstone Ave. BOW. 28, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/12/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>DEC 14 1966</u>									

MEDICAL CERTIFICATION

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16673

## CERTIFICATE OF DEATH

16675

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> d. STREET ADDRESS <b>3609 Courtleigh Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>C</b> Last <b>Downes</b>		4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1873</b>	
9. AGE (in years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman - Straus Bros.</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		13. CITIZEN OF WHAT COUNTRY?	
14. FATHER'S NAME <b>? Downes</b>		15. MOTHER'S MAIDEN NAME <b>Mary Britton</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>216-09-0320</b>	
18. INFORMANT <b>Mr. Cecil Downes</b>		Address <b>same address as above</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Arterio Sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>34 hrs.</b> <b>25 yrs.</b> <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arterio Sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 31, 1955</b> , to <b>Dec. 4, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 4, 1966</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>12/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4108 Liberty Hts. Balto Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. F. Tabner &amp; Sons North Ave. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Handwritten notes and markings, including the word "Bismarck" and other illegible text, scattered across the middle section of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16674					16676				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			d. STREET ADDRESS <u>1924 Augusta Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1924 Augusta Ave.</u>					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>DRAWER</u> Last <u>DRAWER</u>					4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquors</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Russia</u>			
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Marie Drawer 1924 Augusta Ave.</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Severe intestinal bleeding</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>24 Dec 1966</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>23 Dec 1966</u> to <u>24 Dec 1966</u> , that (I) (we) last saw the deceased alive on <u>23 Dec 1966</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Herbert Morrison</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>26 Dec 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>W. Herbert Morrison, M.D.</u>					22d. ADDRESS <u>3 Kinship Road</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Christ Lutheran Cemetery</u>		23d. LOCATION (City, town or county) <u>Dundalk, Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home Dundalk, Md.</u>					ADDRESS		25. REC'D BY REGISTRAR <u>DEC 30 1966</u>		
							25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		

10036

LEAVES OF CHINA

10036

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
UNITED STATES DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.  
1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16675 CERTIFICATE OF DEATH 16677

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>56 Greater Baltimore Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30.4 Baltimore</u> d. STREET ADDRESS <u>908 Dartmouth Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RONALD</u> First <u>HOLLAND</u> Middle <u>DUNN JR.</u> Last 4. DATE OF DEATH <u>12 - 21</u> Month <u>1966</u> Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ronald Holland Dunn</u> 14. MOTHER'S MAIDEN NAME <u>Verona Lambert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> 16. SOCIAL SECURITY NO. <u>NA</u> 17. INFORMANT <u>Patient's Chart</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Pneumonia, probably viral</u> DUE TO (c) <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2dc. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. 2dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2df. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 21</u> , 19 <u>66</u> to <u>Dec 21</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>66</u> , and that death occurred at <u>5<sup>45</sup></u> P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Norman Fost</u> 22b. DATE SIGNED <u>12-21-66</u> 22c. PHYSICIAN'S NAME (Type) <u>NORMAN FOST</u> 22d. ADDRESS <u>Greater Baltimore Medical Ctr.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/24/1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> 23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Rd. Balto. 12, Md.</u> 25a. REC'D BY REGISTRAR <u>DEC 27 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

16676

# CERTIFICATE OF DEATH

16678

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>46 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>5517 SEFTON AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE JAMES DUTROW</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 20 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 28, 1893</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCCER</b>	11. BIRTHPLACE (County & State, or foreign country) <b>EMMITSBURG, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH DUTROW</b>	
14. MOTHER'S MAIDEN NAME <b>ELLA CHILES Childs Childs</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>	
16. SOCIAL SECURITY NO. <b>212 10 92 43</b>		17. INFORMANT <b>VA HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>UNKNOWN ORGANISM</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PYELONEPHRITIS DUE TO E. COLI, DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>NOV 4, 19 66</b> to <b>DEC. 20, 19 66</b> , that (we) last saw the deceased alive on <b>DEC. 20, 19 66</b> , and that death occurred at <b>210 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>W. J. Hahn</i> M.D.		22b. DATE SIGNED <b>12-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WON JU HAHN, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/23/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>RUCKS FUNERAL HOME, 5300 HARFORD RD, BALTIMORE, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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16677

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, nine to burial cremation or removal within 72 hours after death.

1. NAME OF DECEASED (Type or Print) <b>BERNARD DWORKIN</b>			2. DATE AND HOUR OF DEATH <b>December 6, 1966</b>   <b>9</b> A. M.		
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b> <b>BALTIMORE COUNTY</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>BALTIMORE - 21207</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTIMORE</b>		
5. SEX <b>Male</b>			6. RACE <b>White</b>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>			8. DATE OF BIRTH <b>March 17, 1922</b>		
9. AGE (In years last birthday) <b>44</b>			10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>State of Maryland</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel Dworkin</b>			14. MOTHER'S MAIDEN NAME <b>Pauline ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. II Army</b>			16. SOCIAL SECURITY NO. <b>215-14-4301</b>		
17. INFORMANT <b>Mrs. Gilda Dworkin, 3923 Southern Cross Dr.</b>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>330X ANTECEDENT CAUSES</b>			CAUSE OF DEATH (A) <b>Cardio-Respiratory Failure</b> DUE TO (B) <b>Subarachnoid Hemorrhage</b> DUE TO (C)		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
20. I certify that (I) (this hospital) attended the deceased from <b>Feb 6</b> 19 <b>61</b> to <b>Dec 6</b> 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 6</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Willard Applefeld</b>			23B. DATE SIGNED <b>12/7/66</b>		
23C. PHYSICIAN'S NAME (Type) <b>Willard Applefeld</b>			23D. ADDRESS <b>Park Heights &amp; Glen Avenues</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12/7/66</b>		
24C. NAME OF CEMETERY or CREMATORY <b>Ohel Yakov</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 8 1966</b>			25B. NAME OF REGISTRAR <b>Charles Judge</b>		
25C. FUNERAL DIRECTOR <b>Sol Lexinson &amp; Bros. Inc., 6010 Reisterstown</b>			ADDRESS		



10033

STATE OF MARYLAND

10033

Blank form with faint horizontal lines and vertical columns, likely a ledger or record book.

DO NOT WRITE IN THESE SPACES  
THIS SPACE IS RESERVED FOR THE OFFICE OF THE ATTORNEY GENERAL  
AND FOR THE OFFICE OF THE COMPTROLLER OF THE TREASURY

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**16678**

**CERTIFICATE OF DEATH**

**16680**

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>			c. LENGTH OF STAY IN 1b <b>8 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2102 Folkstone Rd. 21093</b>				d. STREET ADDRESS <b>2102 Folkstone Rd. 21093</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>EBERLE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>May 5, 1897</b>	
				9. AGE (In years lost birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receiving Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Social Security</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York City</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Henry Eberle Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Huether</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>060-09-2334</b>		17. INFORMANT Address <b>Mrs. Josephine K. Eberle 2102 Folkstone Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>154X</b> IMMEDIATE CAUSE (a) <b>Cachexia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Locally extensive and metastatic adenocarcinoma</b> DUE TO (c) <b>Adenocarcinoma of rectum</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 months.</b> <b>18 months.</b> <b>30 months.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>July 30 1965</b> , 19 to <b>Dec. 10</b> , 19 <b>66</b> , that (1) (we) last saw the deceased alive on <b>Dec. 8</b> , 19 <b>66</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>J. Walter Smyth</i>				22b. DATE SIGNED <b>Dec 12, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Walter Smyth</b>	
				22d. ADDRESS <b>550 N. Broadway</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-14-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson Inc. Towson, Maryland</b>				25. REC'D BY REGISTRAR <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16679 CERTIFICATE OF DEATH 16681

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>30.4</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3104 Savy St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thurston W. Edmunds</b>		4. DATE OF DEATH Month <b>12.</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 24 10</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Driver</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Bernard Edmunds</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Hastig</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>217-14-5874</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinoma Tosis</b> <b>141.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous cell carcinoma of tongue</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary Tuberculosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8 16 1966</b> to <b>12 5 1966</b> , that (I) (we) last saw the deceased alive on <b>12 5 1966</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm. Newcomer</b>		22b. DATE SIGNED <b>12.5.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-7-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn Md.</b>	
24. FUNERAL DIRECTOR <b>G. Howard Strong 3207 W. North Ave..</b>		25a. REC'D BY REGISTRAR <b>DEC 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10041

10039

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mount Wilson State Hospital

Mount Wilson, Maryland

Superintendent, Mount Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>16680</p> </div> <div> <p>16682</p> </div> </div> <div style="text-align: center;"> <p>1</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div>													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>30.4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>127 E Fort Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MAHERINE</u> Middle <u>Ehlers</u> Last <u>—</u>						4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1966</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/23/82</u>		9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Louis C.</u>						14. MOTHER'S MAIDEN NAME <u>Mary J. Bayne</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family - Same</u> Address <u>—</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Septic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>												INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Terminal pneumonia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>			20f. (City or town) (County) (State) <u>—</u>				
21. I certify that (I) (this hospital) attended the deceased from <u>June 4</u> , 19 <u>49</u> , to <u>Dec 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 14</u> , 19 <u>66</u> , and that death occurred at <u>2:22 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>H.P. Friedman</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/14/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>H.P. FRIEDMAN, M.D.</u>						22d. ADDRESS <u>1319 Light St. Balt. Md. 21230</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		23b. DATE THEREOF <u>12/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore</u>					
24. FUNERAL DIRECTOR <u>1400 E. Fort Ave</u> ADDRESS <u>—</u>						25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

John Smith

Thomas Jones

On 12th of 1880

1880

1880



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16681

16683

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>21 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> d. STREET ADDRESS <b>5313 Patterson Rd</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANTHONY (MIDDLE) ELEBESETO</b>				4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-23-1901</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>15</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Refinishing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>France</b>				12. CITIZEN OF WHAT COUNTRY? <b>France</b>			
13. FATHER'S NAME <b>EMANUEL ELEBESETO</b>				14. MOTHER'S MAIDEN NAME <b>BEATRICE (?)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-26-6291</b>			
17. INFORMANT <b>Samuel Cammelli - 14425 Brad Dr., Rockville, Md.</b>				Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instantly</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pulmonary tuberculosis, active</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (this hospital) attended the deceased from <b>11-18-1966</b> to <b>12-9-1966</b> , that (we) last saw the deceased alive on <b>12-9-1966</b> , and that death occurred at <b>7:30</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				22b. DATE SIGNED <b>12-9-1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>				22d. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 13, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Humphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>DEC 16 1966</b>			

ADDRESS

**8434 Georgia Ave.  
Silver Spring, Md.**

10000

10000

Belknap County

Mount Wilson

Mount Wilson State Hospital

AMERICAN (W) BUREAU

V

W

M

Mount Wilson State Hospital

AMERICAN (W) BUREAU

Mount Wilson State Hospital

Mr. Raymond, N.D. Superintendent, Mount Wilson, Maryland

Belknap County, N.D.

Belknap County, N.D.

Belknap County, N.D.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16682

CERTIFICATE OF DEATH

16684

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>		d. STREET ADDRESS <b>Box 567 Winans Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BALTIMORE COUNTY GENERAL Hosp</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WENDELA E. ELIASON</b>		4. DATE OF DEATH <b>DECEMBER 2, 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-22-86</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR: Months <b>03</b> Days <b>1</b> Hours <b>00</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SWEDEN</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>SWEDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>SWEDEN</b>	
13. FATHER'S NAME <b>WALTER HEDMAN</b>		14. MOTHER'S MAIDEN NAME <b>HANNA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dan Petza</b>		Address <b>Box 567 Winans Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>massive aspiration of gastric content</b> 420.1 DUE TO <b>Acute myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-24, 1966</b> to <b>12-2, 1966</b> that (I) (we) last saw the deceased alive on <b>12-2, 1966</b> , and that death occurred at <b>10:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Balbino Tayas, Jr.</b>		22b. DATE SIGNED <b>12-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>BALBINO TAYAS, JR.</b>		22d. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto., Md.</b>
24. FUNERAL DIRECTOR <b>H. J. Eckhardt</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Owings Mills, Md.</b>		DATE <b>DEC 3 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

12331

2862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16683

## CERTIFICATE OF DEATH

16685

1. PLACE OF DEATH, a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21214</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			d. STREET ADDRESS <b>2926 E. Northern Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Bernard</b> Last <b>ELLINGHAUS</b>			4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1893</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles B. Ellinghaus</b>			14. MOTHER'S MAIDEN NAME <b>Eva Hager</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW I</b>		16. SOCIAL SECURITY NO. <b>215051573A</b>		17. INFORMANT <b>C. Bernard Ellinghaus</b> Address <b>9521 Powder Horn Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive heart failure</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/12/</b> , 1966, to <b>12/28/</b> , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/28/</b> 1966, and that death occurred at <b>7:35AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Mr. Chang</b>			22b. DATE SIGNED <b>12/28/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Myung Y. Chang, M.D.</b>
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>12-31-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc Baltimore, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10025

LABORATORY OF DETAIL

10083

10083

10083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16684

16686

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON Md.</u>		c. LENGTH OF STAY IN 1b <u>30 da. 1/2 hr.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME.</u>				d. STREET ADDRESS <u>311 HIGHFALCON Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lucy</u>		First <u>Lucy</u> Middle <u>V.</u> Last <u>EMGE</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1899</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Viola Chester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>216-50-2933</u>		17. INFORMANT <u>NANCY EMGE</u>		Address <u>311 HIGHFALCON Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per life for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> 1562 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) <u>Metastatic carcinoma of liver</u> OUE TO (c) <u>Carcinoma - primary site undetermined</u>						INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 7</u> , 19 <u>66</u> , and that death occurred at <u>2:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip Bernstein</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u></u>		22b. DATE SIGNED <u>Dec. 7, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u></u>				22d. ADDRESS <u>112 CHARTLEY DR, REISTERSTOWN, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn Md</u>	
24. FUNERAL DIRECTOR <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Rd</u>		25a. REC'D BY REGISTRAR <u>Randallston Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 9</u>				YEAR <u>1966</u>			



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William Jackson

DEC 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
16685					16687									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)									
a. COUNTY <i>Baltimore</i>					a. STATE <i>Pennsylvania</i> b. COUNTY <i>Schuykill</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
<i>Cockeyville</i>					<i>Delano</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS									
<i>Falls Road Box 267</i>					<i>106 Hazle Street</i>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last <i>Charles Clinton Engle</i>					Month Day Year <i>December 21 1966</i>									
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
<i>Male</i>		<i>White</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>8 January 1889</i>		<i>77</i> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
<i>Machinist</i>			<i>Lehigh Valley RR</i>			<i>Delano, Pa</i>			<i>USA</i>					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
<i>Clinton Engle</i>					<i>Margaret Reynolds</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT				
<i>yes</i>					<i>115-14-3898</i>					<i>wife - money same</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										<i>3 days</i>				
DUE TO <i>Cerebral Vascular Accident</i>														
DUE TO <i>Cerebral Vascular Arteriosclerosis</i>										<i>small</i>				
DUE TO <i>Generalized Arteriosclerosis</i>										<i>10 years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
Hour a.m. p.m. <i>19</i>					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>19 Dec 66</i> to <i>Dec 19 66</i> , that (I) (we) last saw the deceased alive on <i>19 Dec 66</i> and that death occurred at <i>24</i> M, from the causes and on the date stated above.														
22a. SIGNATURE					22b. DATE SIGNED									
<i>Walter T. Kees</i>					<i>21 Dec 66</i>									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
<i>WALTER T. KEES</i>					<i>Cockeyville, Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
<i>Burial</i>								<i>Pennsylvania</i>						
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
<i>Wm. Cook-Brooks Towson</i>					<i>1050 York Road Towson, Maryland 21204</i>					<i>DEC 23 1966</i>				
										<i>Charles Judge</i>				

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CONTINUED OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16686 CERTIFICATE OF DEATH 16688

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>4 hours</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 21212</b>		d. STREET ADDRESS <b>528 MURDOCK RD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSE ISABELLE ENSMINGER</b>		First		Middle		Last		4. DATE OF DEATH <b>DEC. 3rd 1966</b>		Month		Day		Year	
5. SEX <b>F</b>		6. COLOR OR RACE <b>Can.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>05-14-98</b>		9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army Civil Ser.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>???????</b>		14. MOTHER'S MAIDEN NAME <b>Hohrein</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-07-7547</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-07-7547</b>		17. INFORMANT <b>WM. R. Ensminger, 7400 Stanmore Ct., Balto.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 3, 1966</b> , to <b>DEC 3, 1966</b> , that (I) (we) last saw the deceased alive on <b>DEC. 3 1966</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>M. Isabelle MacGregor</b>		22b. DATE SIGNED <b>12-3-66</b>		22c. PHYSICIAN'S NAME (Type) <b>ISABELLE MAC GREGOR</b>		22d. ADDRESS <b>Greater Baltimore Medical Centre</b>		22e. REC'D BY REGISTRAR <b>DEC 5 1966</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Parkville, Balto. Co., Md.</b>		24. FUNERAL DIRECTOR <b>W. Cook-Brooks Towson, Inc.</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					
24. FUNERAL DIRECTOR <b>W. Cook-Brooks Towson, Inc.</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		24c. ADDRESS <b>Towson, Md. 21204</b>		24d. DATE <b>DEC 5 1966</b>		24e. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		24f. DATE <b>DEC 5 1966</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16687

# CERTIFICATE OF DEATH

16689

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Hall</b> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4100 Westmeath Road</b>				d. STREET ADDRESS <b>4100 Westmeath Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>S.</b> Last <b>Entrikin</b>				4. DATE OF DEATH Month <b>December</b> Day <b>24</b> , Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1911</b>	
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>John T. Entrikin</b>				14. MOTHER'S MAIDEN NAME <b>Caroline A. Windnagel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>213-05-2711</b>		17. INFORMANT <b>Mrs. Ella S. Entrikin</b> Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma (site unknown)</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>8 mo</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-15</b> , 19 <b>66</b> , to <b>12-24</b> , 19 <b>66</b> , that (I) (we) lost the deceased alive on <b>12-17</b> , 19 <b>66</b> , and that death occurred at <b>6:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Frank G. Kuehn</b>				22b. DATE SIGNED <b>12/24/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank G. Kuehn</b>	
22d. ADDRESS <b>Medical Arts Bldg.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



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RECORD OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21234</u> <u>03.1</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Josephs Hospital</u>										d. STREET ADDRESS <u>3230 Joppa Rd.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>R</u> Last <u>Esslinger</u>										4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>19 66</u>														
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>April 9, 1909</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contracting Supt.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Jesse Esslinger</u>										14. MOTHER'S MAIDEN NAME <u>Margaret Arnt</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>					16. SOCIAL SECURITY NO. <u>  </u>					17. INFORMANT <u>Mr J. Warren Esslinger 14 Dublin Drive 21093</u> Address <u>Lutherville, Md.</u>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the tongue with metastasis</u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>  </u>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)																			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State) <u>30 66</u>									
21. I certify that (I) (this hospital) attended the deceased from <u>December 30, 19 66</u> , to <u>December, 19 66</u> , that (I) (we) last saw the deceased alive on <u>December 30 19 66</u> , and that death occurred at <u>11</u> <u>PM</u> from causes and on the date stated above.																								
22a. SIGNATURE <u>Fiorello G. Malit M.D.</u>										ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22b. DATE SIGNED <u>December 30 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Fiorello G. Malit M.D.</u>										22d. ADDRESS <u>7620 York Rd 21204</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>1-3-1967</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cemetery</u>					23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>									
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>										25a. REC'D BY REGISTRAR <u>13 6</u> DATE <u>JAN 3 1967</u>										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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Handwritten signature and date: 10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16689

CERTIFICATE OF DEATH

16691

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 yrs - 6 months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>		d. STREET ADDRESS <b>Avenue B, Todds Farm</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLGA</b> Middle <b>FABERSTON</b> Last <b>DECEMBER 25</b> 1966		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14-1887</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Finland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>August Lindh</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Forstram</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-4755</b>	
17. INFORMANT <b>Mrs. Esther Morris, Todds Farm, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (shock)</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-19</b> , 19 <b>66</b> , to <b>DEC. 25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 25</b> , 19 <b>66</b> , and that death occurred at <b>9:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. Taheri</b>		22b. DATE SIGNED <b>12-26-1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Amanollah Taheri</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 28-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland 21224</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16774

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16692

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>13 y.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1410 FOREST PARK AVE #07</b>		d. STREET ADDRESS <b>1410 FOREST PARK AVE #07</b>	
3. NAME OF DECEASED (Type or print) <b>MARTIN, JONATHAN FAHEY</b>		4. DATE OF DEATH <b>12/25/66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/4/1883</b>
9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	
11. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN FAHEY</b>		14. MOTHER'S MAIDEN NAME <b>BRIGITTE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-07-6491</b>	
17. INFORMANT <b>WIFE</b>		Address <b>1410 FOREST PARK AVE #07</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Vascular</b> <b>450.0</b> DUE TO <b>obese</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edmund Kasaitis</b> M.D.		22. DATE SIGNED <b>Dec. 25, 1966</b>	
EXAMINER'S NAME (Type) <b>EDMUND KASAITIS, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO MARYLAND</b>
24. FUNERAL DIRECTOR <b>WEGER FUNERAL HOME 5311 EDMONDSON AVE</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>						c. LENGTH OF STAY IN ID <u>30.4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MILFORD Manor Nursing Home</u>						d. STREET ADDRESS <u>7121 Park Heights Avenue, Apt 402</u>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>LOUIS</u> Middle <u>—</u> Last <u>FARBER</u>						<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>25</u> Year <u>1966</u>					
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b>		<b>9. AGE</b> (In years last birthday) <u>86</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Contractor</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Austria</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT</b> Address <u>Mr. Adolph Farber, 222 N. Eutan St. #1</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>—</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>UNKNOWN</u> <u>UNKNOWN</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov</u> , 19 <u>65</u> , to <u>12/25, 1966</u> , that (II) (we) last saw the deceased alive on <u>12/23</u> 19 <u>66</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>B R Shochet, MD</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12/25/66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Bernard R. Shochet, MD</u>						<b>22d. ADDRESS</b> <u>6804 Park Heights Ave #5</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/26/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bnai Israel</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 28 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



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**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**16691**

**CERTIFICATE OF DEATH**

**16694**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>_____</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>20 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21213</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>3017 SHANNON DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS P. FARRELL</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 14 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 10, 1900</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Y.M.C.A.</b>		13. FATHER'S NAME <b>JOHN FARRELL</b>	
13. FATHER'S NAME <b>JOHN FARRELL</b>				14. MOTHER'S MAIDEN NAME <b>ANNA KIMMITT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 03 10 88</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE, MASSIVE</b> DUE TO <b>ADENOCARCINOMA PANCREAS WITH INVASION OF STOMACH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>METASTATIC ADENOCARCINOMA</b> <b>WIDESPREAD</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>MONTHS</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/24/66</b> , 19__ to <b>12/14/66</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>12/14/66</b> , 19__, and that death occurred at <b>12:35A</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>George Dudas</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
3331 Brehm's Lane, Balto. Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16692

16695

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>10yr2mth26dys</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> d. STREET ADDRESS <b>1118 "H" Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>G.</b> Last <b>Findley</b> Sr. 5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Aug. 16, 1889</b> 9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer, retired</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Open Hearth James Findley</b> 14. MOTHER'S MAIDEN NAME <b>Catherine McCoy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> 16. SOCIAL SECURITY NO. <b>213-07-9933X</b> 17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Arteriosclerotic heart disease with old myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Right hemiplegia due to old cerebrovascular accident</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10:10</b> to <b>Dec. 7</b> , 19 <b>66</b> that (he) (we) last saw the deceased alive on <b>Dec. 7</b> , 19 <b>66</b> , and that death occurred at <b>8:10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b> 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED <b>12-7-66</b> 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/10/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Hephzibah Baptist Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Coatsville Chester Co. Pa.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16693

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16696

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Professional House 133 Slade Ave.</u>		d. STREET ADDRESS <u>6420 Park Heights Ave. Bancroft Apts.</u>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Fish</u> Last <u>Fish</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Israel Gerber</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Feldman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>Mr. Herman Fish 429 N. Eutaw Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201X HODGKINS Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1958</u> to <u>12/18, 1966</u> , that (I) (we) last saw the deceased alive on <u>12/17, 1966</u> , and that death occurred at <u>5:30A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert J. Himelfarb</u>		22b. DATE SIGNED <u>12/18/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J. HIMELFARB</u>		22d. ADDRESS <u>3501 ST. PAUL ST. BALTIMORE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shaarei Tfiloh</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson &amp; Bros. 6010 Reisterstown Road #15</u>		25a. REC'D BY REGISTRAR <u>DEC 21 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16694

CERTIFICATE OF DEATH

16697

1. PLACE OF DEATH a. COUNTY <u>Balto. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN lb <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Md</u> <u>30.4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pickersgill</u>				d. STREET ADDRESS <u>2928 E Fayette ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie S. Fleckenschildt</u> First Middle Last				4. DATE OF DEATH <u>Dec. 28</u> 19 <u>66</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28 1873</u>		9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Fleckenschildt</u>				14. MOTHER'S MAIDEN NAME <u>Clementine Johannis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-01-5578</u>		17. INFORMANT <u>M. Weaver RN 616 Springfield</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Bronchopneumonia, bilateral</u> DUE TO <u>HASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u> years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>66</u> , to <u>Dec. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28</u> 19 <u>66</u> , and that death occurred at <u>8:20 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Edwin B. Jarrett</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin B. Jarrett, M.D.</u>				22d. ADDRESS <u>11 East Chase St., City-2.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore County, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc.</u>				ADDRESS <u>1050 York Rd. Baltimore, Md. 21204</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

IN RE: THE ESTATE OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u>			c. LENGTH OF STAY IN 1b <u>6 Months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> <u>06.2</u>			d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chapel Hill Nursing Home</u>					d. STREET ADDRESS <u>Obrect Road</u>				
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>CLARK</u> Last <u>Forsyth</u>					4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1879</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur P. Forsyth</u>					14. MOTHER'S MAIDEN NAME <u>Amanda Clark</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-34-5039</u>		17. INFORMANT <u>MR. James Forsyth, Jr - Chestersfield, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Cerebral Thrombosis, Chronic Brain Syndrome</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1964</u> through <u>12/17/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> , to <u>12-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>66</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard E. Hall</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-18-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>					22d. ADDRESS <u>Sykesville, Maryland 21784</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-20-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>Howard G. Md.</u>		
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>					ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

10000

10000

7 Howard E. Hall, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16696

16693

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		d. STREET ADDRESS <u>705 Washington Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>705 Washington Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert Nicholas</u> Middle <u>Frame</u> Last <u>Frame</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1919</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Military Supplies</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Frame</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>11</u>	
17. INFORMANT <u>Family Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>974X</u> IMMEDIATE CAUSE (a) <u>Self-accretion from</u> DUE TO <u>Hanging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Self-accretion</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Depression</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>Hanging from Rope over Pipe in Basement</u>	
20c. TIME OF INJURY Month, Day, Year <u>2</u> <u>5</u> <u>12/26</u> <u>1966</u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles J. O'Donnell</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <u>12/26/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 29, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10031

22031



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>22 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTE.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 21218</b> d. STREET ADDRESS <b>2725 FENWICK AVE.</b>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT CHARLES FREEDY</b> First Middle Last <b>5. SEX</b> <b>M</b> <b>6. COLOR OR RACE</b> <b>W</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>1-8-09</b> <b>9. AGE</b> (In years last birthday) <b>57</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.				<b>4. DATE OF DEATH</b> <b>12 29 1966</b> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>GUARD</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>FRANCHARD CO.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>BALTO. MD.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>JOHN FRANK FREEDY (DEC)</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>WHEELER; Jennie</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>216-03-4350</b> <b>17. INFORMANT</b> <b>RUTH FREEDY</b> Address <b>(SAME)</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Cardio pulmonary failure</b> DUE TO (b) <b>metastatic CARCINOMA</b> DUE TO (c) <b>CARCINOMA OF LUNG.</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from Dec 7, 1966, to Dec 29, 1966, that (I) (we) last saw the deceased alive on Dec 29, 1966, and that death occurred at 2 1/2 M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Chiu-chun Shih</i> <b>22b. DATE SIGNED</b> <b>12-29-66</b>								<b>22c. PHYSICIAN'S NAME</b> (Type) <b>CHIU-CHUN SHIH</b> <b>22d. ADDRESS</b> <b>G.B.M.C.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>12/31/66.</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Memorial Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Baltimore, Md.</b>				<b>24. FUNERAL DIRECTOR</b> <b>Leonard Puck, Inc.</b> ADDRESS <b>Balto. Md. 21214</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 4 1967</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>							

MEDICAL CERTIFICATION



10037

BALTIMORE

TOWSON

GREATER BALTIMORE MEDICAL CENTER 2132 FENWICK AV.

ROBERT

CHARLES FREEDY

12

29

22

1-8-09

W

M

GUARD

FRANKHARD CO. BALTO. MD.

USA

JOHN FRANK FREEDY (son)

WHEELER

RUTH FREEDY (sister)

Card Pulmonary Failure

Intestine Effacement

GASTRITIS OF LUNG

12 29 09

Baltimore, Md.

Central National Cemetery

10/1/00

10/1/00

10/1/00

10/1/00

Frederick C. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
16698											
16701											
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 9</b>					
c. LENGTH OF STAY IN 1b <b>2 1/2 mo.</b>						d. STREET ADDRESS <b>1305 Appleby Ave</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Margaret Josephine GABLE</b>						4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>1966</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12.27.1912</b>		9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WALTER SEWELL</b>						14. MOTHER'S MAIDEN NAME <b>BLANCHE BROOKS</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>8</b>		17. INFORMANT <b>Records, Mount Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> DUE TO (b) <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>10.7.1966</b> , to <b>12.22.1966</b> , that (I) (we) last saw the deceased alive on <b>12.22.1966</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Wm. Newcomer</b> 22b. DATE SIGNED <b>12.22.66</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b> 22d. ADDRESS <b>Mount Wilson, Maryland</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/27/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b> 23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b> 24. FUNERAL DIRECTOR <b>Austin E. Donovan</b> ADDRESS <b>3818 Roland Ave</b> 25a. REC'D BY REGISTRAR <b>DEC 27 1966</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

15701

15028

Washington County

Mount Wilson

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson State Hospital

Mr. Woodlawn, R.D. Superintendent Mount Wilson, Maryland

Woodlawn, Md

Woodlawn

12/27/66

12/27/66

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

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1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16699

16702

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u> c. LENGTH OF STAY IN b <u>40 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>709 A Baurenschmidt Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u> d. STREET ADDRESS <u>709 A BAURENSCHMIDT DR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>Gentile</u> Last <u>Gentile</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28 1889</u> 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stonemason</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Antonio Gentile</u>		14. MOTHER'S MAIDEN NAME <u>Antoinetta Bauernsch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.I</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>051-14-0031</u> 17. INFORMANT <u>Mr. Frank Gentile</u> Address <u>709 A Bauernsch</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>A-S-C-V-DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Ch. of her lung (opened Nov.-66)</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No No</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		22. DATE SIGNED <u>12/3/66</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis</u>		M.D. <u>MD-6800</u> Address (Street, city, town, or county) <u>Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/5/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph N. Zannino</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 7 1966</u>		25c. ADDRESS <u>263 S. Conkling St.</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 16703

16700

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CHESAPEAKE MANOR NURSING HOME</b>		d. STREET ADDRESS <b>5712 ROLAND AVE</b>	
3. NAME OF DECEASED (Type or print) <b>SISTER MARY CLEMENT GERHARDT</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/89</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RELIGIOUS SISTER OF THE VISITATION</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PHILA, PENNA</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>FRANCIS GERHARDT</b>		14. MOTHER'S MAIDEN NAME <b>CAROLYN SCHMIDT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MOTHER M. XAVIER</b>		Address <b>5712 ROLAND AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Cardio Vascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>DEC 16 1966</b> to <b>DEC 18 1966</b> , that I last saw the deceased alive on <b>DEC 16 1966</b> , and that death occurred at <b>2 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Wm L Helfrich</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>William G. Helfrich, MD.</b>		<b>5006 Roland Avenue # 21210</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/20/66</b>	22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 22 1966</b>		24b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10705

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		M		45		JAN 15 1950	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
PLACE OF DEATH		DATE OF BIRTH		PLACE OF BIRTH		RACE	
HOME		JAN 1 1905		BALTIMORE, MD		WHITE	
EDUCATION		SCHOOLING		MARRIAGE		RELIGION	
HIGH SCHOOL		8 YEARS		MARRIED		METHODIST	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF ALCOHOLISM		HISTORY OF DRUGS	
NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		RACE	
JAN 15 1950		10:00 AM		HOME		WHITE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16701						16704					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore #6</u> <u>30-4</u> d. STREET ADDRESS <u>5528 Hilltop Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Florence</u> First <u>Laveria</u> Middle <u>GERLAND</u> Last			4. DATE OF DEATH <u>12</u> Month <u>18</u> Day <u>19</u> Year <u>66</u>			5. SEX <u>female</u>			6. COLOR OR RACE <u>white</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>2-14-'02</u>			9. AGE (In years last birthday) <u>64</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Oliver Barger</u>						14. MOTHER'S MAIDEN NAME <u>Marie Catherine Barger Duffey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-46-7109</u>			17. INFORMANT <u>Mr. Francis Gerland</u> Address <u>8448 Oakleigh Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>172X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Myocardial infarction</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>30-45 min</u> <u>3 mos.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>66</u> , to <u>12/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Ruth M. Allen</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>12/18/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>RUTH M. ALLEN</u>						22d. ADDRESS <u>5670 THE ALAMEDA BALTO. 12, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/22/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Leonard Ruck, Inc. Balto. Md. 21214</u>						25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16702

## CERTIFICATE OF DEATH

16705

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>5 months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			12-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>Rd # 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Kreig Gilbert</b>				4. DATE OF DEATH Month Day Year <b>December 26 19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED NEVER MARRIED <input type="checkbox"/> -WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 20, 1887</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <del>Unknown</del> <b>Frederick Kreig</b>				14. MOTHER'S MAIDEN NAME <del>Unknown</del> <b>Ernestine Schuster</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-22-0748</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>7-22-66</b> , 19 <b>66</b> , to <b>12-26</b> , 19 <b>66</b> that <b>10</b> (we) last saw the deceased alive on <b>Dec. 26</b> , 19 <b>66</b> , and that death occurred at <b>8:05AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>A. Taheri</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Amanollah Taheri</b>				22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>28 Dec. 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smith Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wells &amp; Macomber Sr.</b>				ADDRESS <b>Aberdeen, Md.</b>		25. REGISTRATION BY REGISTRAR <b>DEC 28 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16703

## CERTIFICATE OF DEATH

16706

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <span style="float: right;">✓</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <span style="float: right;">30-4</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1020 BETHUNE ROAD</b>			
<b>3. NAME OF DECEASED</b> First Middle Last <b>HARVEY GILBERT</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>DECEMBER 10 19 66</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>NEGRO</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>FEBRUARY 11, 1908</b>	
<b>9. AGE</b> (In years last birthday) <b>58</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>HARFORD COUNTY, MARYLAND</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>JAMES A. GILBERT</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>CHARLOTTE ROBINSON</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>218 03 47 77</b>				<b>17. INFORMANT</b> <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) <b>CARCINOMA FLOOR OF MOUTH WITH METASTASIS TO CERVICAL LYMPH NODES, THYROID AND LUNGS</b>	
(c)						<b>UNKNOWN</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DEC 1</b> , 19 <b>66</b> , to <b>DEC 10</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 10</b> , 19 <b>66</b> , and that death occurred at <b>630P</b> M, from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <i>Milton Ginsberg</i>				<b>22b. DATE SIGNED</b> <b>12/13/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>MILTON GINSBERG, M. D.</b>	
<b>22d. ADDRESS</b> <b>VAH FORT HOWARD, MARYLAND</b>				<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			
<b>23b. DATE THEREOF</b> <b>12-16-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>BALTIMORE, NATIONAL</b>		<b>23d. LOCATION (City or Town) (County) (State)</b> <b>BALTIMORE, MARYLAND</b>			
<b>24. FUNERAL DIRECTOR</b> <b>ELROY O. WILSON FUNERAL HOME</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 14 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	
<b>ORLEANS ST. BALTIMORE, MD.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment and in any event, within 72 hours after death.

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16704

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16707

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bengies Road (Box 3000)</b>				d. STREET ADDRESS <b>Bengies Road (Box 3000)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>SANDRA</b> Last <b>GILBERT</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1940</b>		9. AGE (In years last birthday) <b>26 20</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dishwasher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore Gilbert</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Cooper</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-40-4939</b>		17. INFORMANT <b>Orville E. Williams, Jr., Bradshaw, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>916.0</b> IMMEDIATE CAUSE (a) <b>Massive Body Burns and Carbon Monoxide</b> <del>XXXX</del> Intoxication. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Conflagration of home.</b>					
20c. TIME OF INJURY Month, Day, Year <del>XXXX</del> <b>12/13 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Essex Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>12/13/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		23d. LOCATION (City or Town) (County) (State) <b>Magnolia Harford Md</b>	
24. FUNERAL DIRECTOR <b>George W. TITTLE, BEL AIR MD</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10701

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>16705</span> <span>CERTIFICATE OF DEATH</span> <span>16708</span> </div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MD</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr23dys</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21210</b>				03.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>						d. STREET ADDRESS <b>4301 Roland Ave. 16 Fusting Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie</b>			First <b>R.</b> Middle <b>Glennon</b> Last			4. DATE OF DEATH <b>December 30 1966</b>			Month <b>30</b> Day <b>1966</b> Year		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27, 1893</b>		9. AGE (In years last birthday) <b>72 73 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>72</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John V. Glennon</b>						14. MOTHER'S MAIDEN NAME <b>Sadie R. Arnold</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFIRMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction with aneurysmatic dilation of left ventricle</b> DUE TO (c) <b>Arteriosclerosis, generalized - severe</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>Nov. 13</b> , 19 <b>64</b> , to <b>December 30. 66</b> that (we) last saw the deceased alive on <b>12-30-</b> 19 <b>66</b> , and that death occurred at <b>4:15</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Stella Wachslar</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-30-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>						22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan 3 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford road</b>						25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



16706

# CERTIFICATE OF DEATH

16709

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> c. LENGTH OF STAY IN 1b <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. CO. GEN. HOSP</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLTOWN</u> <u>23.1</u> d. STREET ADDRESS <u>6744 F. Townbrook Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Bernard LEONARD Goldfadin</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>12 - 31 - 1966</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-14</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CO.</u> <u>Grand Rapid Furniture</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>HARRY Goldfadin</u>				
14. MOTHER'S MAIDEN NAME <u>Beatrice Green</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>199-03-0794</u>			17. INFORMANT Address #7 <u>Mrs. Rose Goldfadin, 6744 Townbrook Dr. Apt F</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.8 METASTATIC CARCINOMA OF THE COLON</u> DUE TO (b) <u>9 months</u> (c) <u>UREMIA DUE TO URETERAL OBSTRUCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from <u>12-9-1966</u> , to <u>12-31-1966</u> , that (I) (we) last saw the deceased alive on <u>12-31-1966</u> , and that death occurred at <u>5:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Quintin L. Uy</u>			22b. DATE SIGNED <u>12/31/66</u>		22c. PHYSICIAN'S NAME (Type) <u>QUINTIN L. Uy</u>		
22d. ADDRESS <u>BALTO. COUNTY GEN. HOSP.</u>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mikro Kodesh-Beth Israel</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	24. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>			
25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

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CONFIDENTIAL

18308

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO</u> <u>B.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House in the Plains</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30.4</u> d. STREET ADDRESS <u>747 W. Cross St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>CARROLL</u> <u>J.</u> <u>GRACE</u>			<b>4. DATE OF DEATH</b> Month <u>12</u> - Day <u>6</u> - Year <u>1966</u>			<b>5. SEX</b> <u>M</u>			<b>6. COLOR OR RACE</b> <u>W</u>		
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>7-10-58</u>			<b>9. AGE (In years last birthday)</b> <u>78</u> yrs.			<b>IF UNDER 1 YEAR</b> Months <u>12</u> Days <u>6</u> Hours <u>19</u> Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Maintenance Man Steel Co.</u>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Steel Co.</u>					<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>					<b>13. FATHER'S NAME</b> <u>Cornel Grace</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					<b>16. SOCIAL SECURITY NO.</b> <u>                    </u>					<b>17. INFORMANT</b> <u>Mrs Genevieve Matthews - Blue</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 wks.</u> <u>1035</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7-3-</u> , 19 <u>64</u> , to <u>12-6-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-6</u> , 19 <u>66</u> , and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Wilmer R. Gallagher</u>								<b>22b. DATE SIGNED</b> <u>12-6-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Wilmer R. Gallagher</u>								<b>22d. ADDRESS</b> <u>6289 Frederick Ave Baltimore 28 Md</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12-9-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Balto</u> <u>Md</u>			
<b>24. FUNERAL DIRECTOR</b> <u>John J. Cowan &amp; Son Inc.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>John J. Cowan &amp; Son Inc.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		<b>DATE</b> <u>DEC 9 1966</u>			

04534



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16708

## CERTIFICATE OF DEATH

16711

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>91 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>4301 Liberty Heights Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>THURKEIL</b> Last <b>GREEN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/14</b>
9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Patterson, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua H. Green</b>		14. MOTHER'S MAIDEN NAME <b>Goldie Reesby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>220-03-92-53</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>9/21</b> , 19 <b>66</b> , to <b>12/21</b> , 19 <b>66</b> , that <del>he</del> (we) last saw the deceased alive on <b>12/21</b> 19 <b>66</b> , and that death occurred at <b>5:00PM</b> from causes on and on the date stated above.			
22a. SIGNATURE <i>Edilberto Anonuevo</i> M.D.		22b. DATE SIGNED <b>12/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDILBERTO ANONUEVO, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wilton R. Webb</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10708

CERTIFICATE OF DEATH

10711

Name of deceased		John A. Brown	
Sex		Male	
Age		35	
Date of birth		1910-10-10	
Place of birth		New York, N.Y.	
Cause of death		Heart disease	
Date of death		1945-10-15	
Place of death		New York, N.Y.	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		1945-10-20	
Place of registration		New York, N.Y.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**16709** **CERTIFICATE OF DEATH** **16712**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore FIKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Professional House 133 Slade Avenue</u>		d. STREET ADDRESS <u>7238 Park Heights Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Leontine Greenebaum</u>		4. DATE OF DEATH <u>December 19, 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 5, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Erstein, France</u>
13. FATHER'S NAME <u>Morris Bloch</u>		14. MOTHER'S MAIDEN NAME <u>Matilda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Mrs. Florine Kaufman, 7111 Park Heights Ave.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 170 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic cancer of breast</u> DUE TO (c) <u>7 1/2 years</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1954</u> to <u>12/19, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/13, 1966</u> , and that death occurred at <u>11 1/2</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Jonas Cohen</u>		22b. DATE SIGNED <u>Dec. 20, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Jonas Cohen</u>		22d. ADDRESS <u>6702 Park Heights Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR <u>DEC 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

16315

16315

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16710

CERTIFICATE OF DEATH

16713

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>910 Courtney Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>L.</b> Last <b>GREINER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-14-1898</b>
9. AGE (In years last birthday) <b>68 Yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Brigerman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Sherwood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>212-28-1290</b>	
17. INFORMANT <b>Mrs. Sylvia M. Hesse, 910 Courtney Rd.</b>		Address <b>21229</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Adenocarcinoma of the uterus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 9mo.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>65</b> , to <b>Dec. 10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/6/66</b> , 19 <b>66</b> , and that death occurred at <b>7:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Herbert J. Levickas</b>		22b. DATE SIGNED <b>12/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Herbert Levickas</b>		22d. ADDRESS <b>1073 Maiden Choice Lane 21229</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-13-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Anne Arundel County, Md.</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25. REC'D BY REGISTRAR <b>DEC 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

18713

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*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "George" and "James" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 16711 CERTIFICATE OF DEATH 16714									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Armacost Nursing Home 812 Register Ave.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>847 West University Parkway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Alice Jones</b>			First Middle Last		4. DATE OF DEATH <b>December 27, 1966</b>		Month Day Year		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 16, 1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas L. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Alice Dickson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. J. Nelson Rickards</b> Address <b>811 Loyola Drive</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> DUE TO <b>Generalized Atherosclerosis</b> DUE TO <b>Cardio Vascular Disease</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1966</b> to <b>Dec 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 19, 1966</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles F. Jones</b>				22b. DATE SIGNED <b>12/27/66</b>		22c. PHYSICIAN'S NAME (Type)			
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/30/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. J. Tubman &amp; Sons</b>				ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

16712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16715

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN It <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>30.4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1701 Woodholme Avenue</b>				d. STREET ADDRESS <b>3407 Batement Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLOTTE GROSS</b>			4. DATE OF DEATH Month <b>December</b> Day <b>31</b> , Year <b>19 66</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18 - 1922</b>	9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Put family</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>THOMAS GROSS</b>			14. MOTHER'S MAIDEN NAME <b>MATILDA HEAVEN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>314-22-8930</b>		17. INFORMANT <b>LeRoy Gross</b> Address <b>3407 Batement Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>January 1, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Calvary</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore 21225</b>	
24. FUNERAL DIRECTOR <b>Thomas Lee P. Hays</b> ADDRESS <b>638 N. Green St.</b>				25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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James Jones

2011-12-15

Thomas Cross

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[illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16713

## CERTIFICATE OF DEATH

16716

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp.</u>		d. STREET ADDRESS <u>6225 Greenspring Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Grosser, Harry Wolf</u>		4. DATE OF DEATH <u>December 18, 1966</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/01</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Lazier Grosser</u>		14. MOTHER'S MAIDEN NAME <u>Pessia Bryna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-109798</u>	
17. INFORMANT <u>Mrs. Esther Grosser</u>		Address <u>6225 Greenspring Avenue</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia; Congestive</u> DUE TO <u>Heart Failure 2° to Ren. KWD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> , 19 <u>66</u> , to <u>12-18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-18</u> , 19 <u>66</u> , and that death occurred at <u>6:30 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. Simon-Payag, M.D.</u>		22b. DATE SIGNED <u>12-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Simon Payag</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forband</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10318

10318

10318

Form with multiple sections and fields, including checkboxes and text areas. The form is oriented vertically and contains various labels and input fields, some of which are partially obscured or illegible due to the image quality. The form appears to be a document for recording information, possibly related to a survey or inspection.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16714

## CERTIFICATE OF DEATH

16717

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KIRBY</b> Middle <b>Mc Manus</b> Last <b>GROVE</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/3/12</b>
9. AGE (In years last birthday) yrs. <b>54</b>		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>10</b> Hours <b>19</b> Min. <b>66</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Roofer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>FREDERICK GROVE</b>		15. MOTHER'S MAIDEN NAME <b>MAMIE SCHATZ</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		17. SOCIAL SECURITY NO. <b>216-03-71-23</b>	
18. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Md.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO <b>CHRONIC BRAIN SYNDROME</b> DUE TO <b>CHRONIC ALCOHOLISM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>12/5/</b> 19 <b>66</b> to <b>12/10/</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12/10/</b> 19 <b>66</b> , and that death occurred at <b>8:55 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Carmelita A. Cendana,</b>		22b. DATE SIGNED <b>12/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARMELITA A. CENDANA, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Loring Byers Funeral Home</b>		25. ADDRESS <b>8728 Liberty Rd. Baltimore, Maryland</b>	
26. REC'D BY REGISTRAR <b>DEC 12 1966</b>		27. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10711

STATEMENT OF DEATH

10711

Name of Deceased		Date of Death	
John Doe		1911-12-15	
Age		35	
Sex		Male	
Marital Status		Single	
Occupation		Teacher	
Cause of Death		Heart Disease	
Place of Death		Home	
Time of Death		10:30 AM	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Statement		1911-12-16	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16715

CERTIFICATE OF DEATH

16718

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ecuador</u> b. COUNTY <u>Quito</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>953 Avenida America</u>	
3. NAME OF DECEASED (Type or print) <u>Grünhut</u> <sup>First</sup> <u>WAST</u> Middle		4. DATE OF DEATH Month <u>Dec.</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-11-97</u> <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Textile Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chocoma, Ecuador</u>		12. CITIZEN OF WHAT COUNTRY? <u>No</u>	
13. FATHER'S NAME <u>Philip Gruenhut</u>		14. MOTHER'S MAIDEN NAME <u>Sandra Hirsch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Isaac Querman</u> Address <u>Baltimore 7, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Acute Coronary Occlusion</u> DUE TO (b) <u>Recent acute Myocardial Infarct</u> DUE TO (c) <u>BPH - post-prostatectomy</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>66</u> , to <u>12-17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-17</u> , 19 <u>66</u> , and that death occurred at <u>8:40 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D. Simon-Pagay</u>		22b. DATE SIGNED <u>12-17-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>December 21, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Frank Newell</u>		25. REC'D BY REGISTRAR <u>DEC 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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## CERTIFICATE OF DEATH

16716

16719

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>2915 Hillcrest Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Alice</b>		Middle <b>Martha</b>		Last <b>HACKER</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-3-1889</b>	
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHANN (REDACTED) WEHRT</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH (REDACTED) BAARK</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Emily Schilling 8135 Pleasant Plains Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of head of Pancreas with Liver Metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>A</b> (this hospital) attended the deceased from <b>11/27/</b> 19 <b>66</b> , to <b>12/14/</b> 19 <b>66</b> , that <b>A</b> (we) last saw the deceased alive on <b>12/14/</b> 19 <b>66</b> , and that death occurred at <b>4 P.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>f. Malek M.D.</b>				22b. DATE SIGNED <b>Dec. 14 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Freidoon Malek</b>	
22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>							
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF <b>12/17/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

16710

STATEMENT OF DEATH

16710

Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to blurriness.

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

CAUSE: \_\_\_\_\_

TIME: \_\_\_\_\_

BY: \_\_\_\_\_

WITNESSES: \_\_\_\_\_

Signature: \_\_\_\_\_

Official Seal: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16717

CERTIFICATE OF DEATH

16720

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN 1b <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Belfast) Md. 03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holly Hill Manor Nursing Home</b>				d. STREET ADDRESS <b>36 Belfast Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Hale</b> Last <b>Hale</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1883</b>		
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <b>03</b> Days <b>17</b> Hours <b>12</b> Min. <b>00</b>		IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Middletown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John B. Kidd</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Shew</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Nola Zaiser W. 119 W. Ridgely Rd. 21093</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compensatory Cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 10</b> , 19 <b>66</b> , to <b>Dec. 17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 17</b> , 19 <b>66</b> , and that death occurred at <b>4:30 AM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>Laurence C. Post</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/19/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>				22d. ADDRESS <b>6805 York Rd Baltimore Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rayville, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CONTRACT OF SALE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16718

## CERTIFICATE OF DEATH

16721

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. LENGTH OF STAY IN 1b <b>6 Weeks</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6112 Hamilton Ave.</b>				d. STREET ADDRESS <b>13 Denton Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Hall</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>December</b> Day <b>15</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/18/17</b>		9. AGE (In years last birthday) <b>49</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife and</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crosse &amp; Blackwell</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Mench</b>				14. MOTHER'S MAIION NAME <b>Ida Benton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-5663</b>		17. INFORMANT (Husband) <b>James Hall</b>		Address <b>21219 13 Denton Ave. Ft. Howard Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF CERVIX</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS.</b>
20a. ACCIOENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OESCRIBE HOW INJURY OCCURREO. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURREO While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, officabldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , to <b>1966</b> , that (I) (we) last saw the deceased alive on <b>14 Dec. 19 66</b> , and that death occurred at <b>2<sup>4</sup></b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul C. Weinberg</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. <b>Dec. 16-1966</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Paul C. Weinberg</b>		22d. ADDRESS <b>M.D. 11 90 W. Belvedere Ave. Balto. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>December 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda</b>				ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION



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Dec. 1-1908

Paul C. Walcott

Dec. 1-1908

Dec. 1-1908

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Dec. 1-1908

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16719

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16722

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ALBERT</b> Last <b>HALL</b>		4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-7-1904</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Repairer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Shoe Repairing</b>	
12. BIRTHPLACE (State or foreign country) <b>Md. Carroll Co</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Wm Hall</b>		15. MOTHER'S MAIDEN NAME <b>Rose Hall</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>218-01-7587</b>	
18. INFORMANT <b>Ellen Wallace</b>		Address <b>1536 Fulton Ave</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Traumatic Injuries</b> DUE TO <b>8/2.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Level Rd.)</b> <b>Deceased was struck by a truck (Old Court Rd. &amp; Scotts</b>	
21a. TIME OF INJURY Month, Day, Year Hour <b>?</b> a.m. <b>12</b> p.m. <b>9</b> 19 <b>66</b>		21b. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22a. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) <b>Street</b>		22b. (City or town) (County) (State) <b>Md.</b>	
23. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker</b>		M.D. <b>Rudiger Breiteneker, M.D.</b>	
EXAMINER'S NAME (Type)		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
25. ADDRESS (Street, city, town, or county)		26. DATE SIGNED <b>12/11/66</b>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27b. DATE THEREOF <b>12-14-66</b>	
27c. NAME OF CEMETERY OR CREMATORY <b>St Thomas</b>		27d. LOCATION (City or Town) (County) (State) <b>Randallstown Md.</b>	
28. FUNERAL DIRECTOR <b>Russell S. Oden - Balto. Md.</b>		29. REC'D BY REGISTRAR <b>DEC 13 1966</b>	
30. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16720 CERTIFICATE OF DEATH 12/27/66-723 16723											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5400 Edmondson Avenue</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>5400 Edmondson Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Frederick Thomas Hanf</b>						4. DATE OF DEATH <b>December 21 1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14, 1883</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Gottlieb Hanf</b>						14. MOTHER'S MAIDEN NAME <b>Catherine Green</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Anna E. Hanf</b> Address <b>same address as above</b>					
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC GLOMERULAR NEPHRITIS</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>10 yrs.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10/15</b> , 19 <b>65</b> , to <b>12/21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> , 19 <b>66</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Norman R. Kleiman</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>NORMAN R. KLEIMAN</b>						22d. ADDRESS <b>3803 EDMONDSON AVE</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Dec. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. J. Tishner &amp; Sons</b>						ADDRESS <b>Baltimore, Md. North Ave</b>		25a. REC'D BY REGISTRAR <b>BEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

05721

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

16721

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16724

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN 1b <b>6 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Back River Neck Rd. Near Cedar Pt. Rd.</b>		d. STREET ADDRESS <b>912 Orems Rd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOAN MARTE HARDING</b>		4. DATE OF DEATH Month Day Year <b>December 18, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Aug. 27, 1940</b>
9. AGE (In years lost birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Steven Fialkowski</b>		14. MOTHER'S MAIDEN NAME <b>Ann Bardar</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>George Harding</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>9731</b> IMMEDIATE CAUSE (a) <b>Asphyxiation due to C.O. Poisoning</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Laid under auto exhaust &amp; inhaled fumes</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>12/18 19--</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Back River Neck Rd.</b>		20f. (City or town) (County) (State) <b>Essex 21 Baltimore</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D. 6800 Mornington Rd. Pundarik 22, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/19/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Edward T. Edwards Fun. Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Edwardsville, Pa.</b>	
24. FUNERAL DIRECTOR <b>James E. Bruzdinski 1407 Eastern Ave. 21</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>James E. Bruzdinski</b>		22. DATE SIGNED <b>12/19/66</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16722

CERTIFICATE OF DEATH

16725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> c. LENGTH OF STAY IN b. <b>031</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1101 Oakland Terrace Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> d. STREET ADDRESS <b>1101 Oakland Terrace Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Linda R. Hardy</b> First Middle Last 4. DATE OF DEATH <b>December 20, 1966</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 7, 1901</b> 9. AGE (In years lost birthday) <b>65</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Sandy T. Mullinix</b> 14. MOTHER'S MAIDEN NAME <b>Margaret Gue</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b> 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Howard T. Hardy, 1101 Oakland Terrace Rd.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease - Sarcoma of Uterus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>60</b> , to <b>12/20</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/19</b> 19 <b>66</b> , and that death occurred at <b>9:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James Nolan</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. James Nolan</b>		22b. DATE SIGNED <b>12/20/66</b> 22d. ADDRESS <b>1 Mallow Hill Road, Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12-23-1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Long Coroner, Maryland</b>		24. FUNERAL DIRECTOR <b>Olin Molesworth, Damascus, Maryland</b> ADDRESS 25a. REC'D BY REGISTRAR <b>DEC 27 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

16733

16733

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**16723**

**CERTIFICATE OF DEATH**

**16726**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>32 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>DAVID</b> Last <b>HARRISON</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>19</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/3/93</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRUM &amp; BARREL MAKER OHIO</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY HARRISON</b>		14. MOTHER'S MAIDEN NAME <b>MOLLY GREENE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>579 10 08 74</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EDEMA</b> (c) <b>ADENOCARCINOMA PANCREAS WITH METASTASIS TO MESENTRY, LYMPH NODES, LIVER AND SPLEEN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that <del>(1)</del> (this hospital) attended the deceased from <b>11/17/66</b> , 19__ to <b>12/19/66</b> , 19__, that <del>(1)</del> (we) last saw the deceased alive on <b>12/19/66</b> , 19__, and that death occurred at <b>5:25 PM</b> , from causes and on the date stated above.		
22a. SIGNATURE <i>George Dudas</i>	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>12/20/66</b>
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>	22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/22/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SALEM CEMETERY</b>
23d. LOCATION (City or Town) (County) (State) <b>CAMBRIDGE, MD.</b>		
24. FUNERAL DIRECTOR <i>Richard M. St. Louis</i>		25. REC'D BY REGISTRAR <b>DEC 30 1966</b>
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16724

CERTIFICATE OF DEATH

16727

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore Co.</u> b. COUNTY <u>Baltimore Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>7 mo. 27 dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor</u>				d. STREET ADDRESS <u>342 Cromwell Bridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ISABELLA</u> First <u>H. G.</u> Middle <u>HART</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/96</u>	9. AGE (In years lost birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School-Volunteer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Ornstein</u>				14. MOTHER'S MAIDEN NAME <u>Teresa Slowik</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>215-44-1690</u>		17. INFORMANT <u>Mr. Wm. S. Hart, Sr.</u>		Address <u>Cromwell Bridge Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic brain syndrome</u> 450.0 DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>Mar 66</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>66</u> , to <u>12/30</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12/30/66</u> 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ernest C Brown Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown, Jr.</u>				22d. ADDRESS <u>550 N. Broadway, Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/31/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>M.F. SADOWSKI &amp; SONS, 1808 Eastern Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Jones</u>	

10138

DEPARTMENT OF COMMERCE

10138

THIS IS TO CERTIFY THAT THE ABOVE NAMED VESSEL WAS LICENSED TO ENGAGE IN THE COASTWISE TRADE OF THE UNITED STATES ON THE 10th DAY OF JANUARY 1913.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16725

## CERTIFICATE OF DEATH

16725

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>				c. LENGTH OF STAY IN lb <b>Glyndon</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Railroad &amp; Albright Ave.</b>				d. STREET ADDRESS <b>Railroad &amp; Albright Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>D.</b> Last <b>Hartman</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1883</b>	9. AGE (In years last birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>66</b> Min.		11. IF UNDER 24 HRS. Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Duff</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Meeheh</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-05-3667</b>		17. INFORMANT <b>Mrs. James E O'Meara</b> Address <b>Glyndon, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Arteriosclerotic Heart Disease</b> DUE TO (b) <b>years</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-25</b> , 19 <b>60</b> , to <b>12-4</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12-3</b> , 19 <b>66</b> , and that death occurred at <b>2:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Clarence E McWilliams</b> M.D.				22b. DATE SIGNED <b>12-5-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Reisterstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>DEC 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10358

EXHIBIT OF RECORD

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THE RECORD OF THE ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 16 Film G 384

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1/12/67 jml

16726

CERTIFICATE OF DEATH

16729

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2629 N. HOWARD STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMELIA GLORIA HAUENSTEIN</b>		4. DATE OF DEATH Month Day Year <b>DEC 25 19 66</b>	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-28-13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>GEORGE PARR</b>		14. MOTHER'S MAIDEN NAME <b>Amanda WEBER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-26-4238</b>	
17. INFORMANT <b>PATIENTS CHART</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary with</b> <b>175.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis. Anemia, Cachexia</b> DUE TO (c) <b>and Cardiac de Compensation 2ndary to it.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12-24</b> , 19 <b>66</b> , to <b>12-25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>66</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Durgadas Kulkarni</b>		22b. DATE SIGNED <b>12-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Durgadas Kulkarni</b>		22d. ADDRESS <b>G.B.M.C. Balt 21204 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 12/28/66</b>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery Woodlawn, Md.</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>Wm. J. Zickner &amp; Sons</b>		25. REGISTERED BY REGISTRAR <b>DEC 27 1966</b>	
ADDRESS <b>Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16727

## CERTIFICATE OF DEATH

16730

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>712 Dundalk Ave. # 21224</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>16 Aigburth Rd., Towson, 4, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA ROSS HEALY</b>				4. DATE OF DEATH <b>December 8, 1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1872</b>	9. AGE (In years last birthday) <b>94 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Work</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rockshirehighlands, Scotland. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ross</b>				14. MOTHER'S MAIDEN NAME <b>JOHANNA GRANT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Rev. Edward Rosa : 600 S. Conkling St.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 mths</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Severe anemia (Hgb 6.4 gm) cause undetermined</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 9, 1966</b> to <b>Dec 8, 1966</b> , that (I) (we) last saw the deceased alive on <b>Aug 6, 1966</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frederick J. Vollmer</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-10-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick J. Vollmer</b>				22d. ADDRESS <b>6100 York Rd., Towson, 4, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>7225 Eastern Blvd. Ba. Co., MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Seiler</b>				ADDRESS <b>901 S. Conkling St. Balto, 24 Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Mr.

Mr. J. J. J.

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TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES

DECEMBER

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16728

CERTIFICATE OF DEATH

16731

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>03.1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b> d. STREET ADDRESS <b>7700 Park Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bonita Gail Herb</b>		4. DATE OF DEATH Month Day Year <b>December 15, 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1947</b>
9. AGE (In years lost birthday) <b>19 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Clair J. Herb</b>		14. MOTHER'S MAIDEN NAME <b>Betty Strohecker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clair J. Herb, father, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>postoperative tonsillectomy</b> DUE TO (c) <b>chronic hypertrophic tonsillitis.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>12/15/</b> , 1966, to <b>12/15/</b> , 1966, that <b>4</b> (we) last saw the deceased alive on <b>12/15/</b> 1966, and that death occurred at <b>10:06M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik</b>		22b. DATE SIGNED <b>12/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/19/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

18731

RECEIVED

18731



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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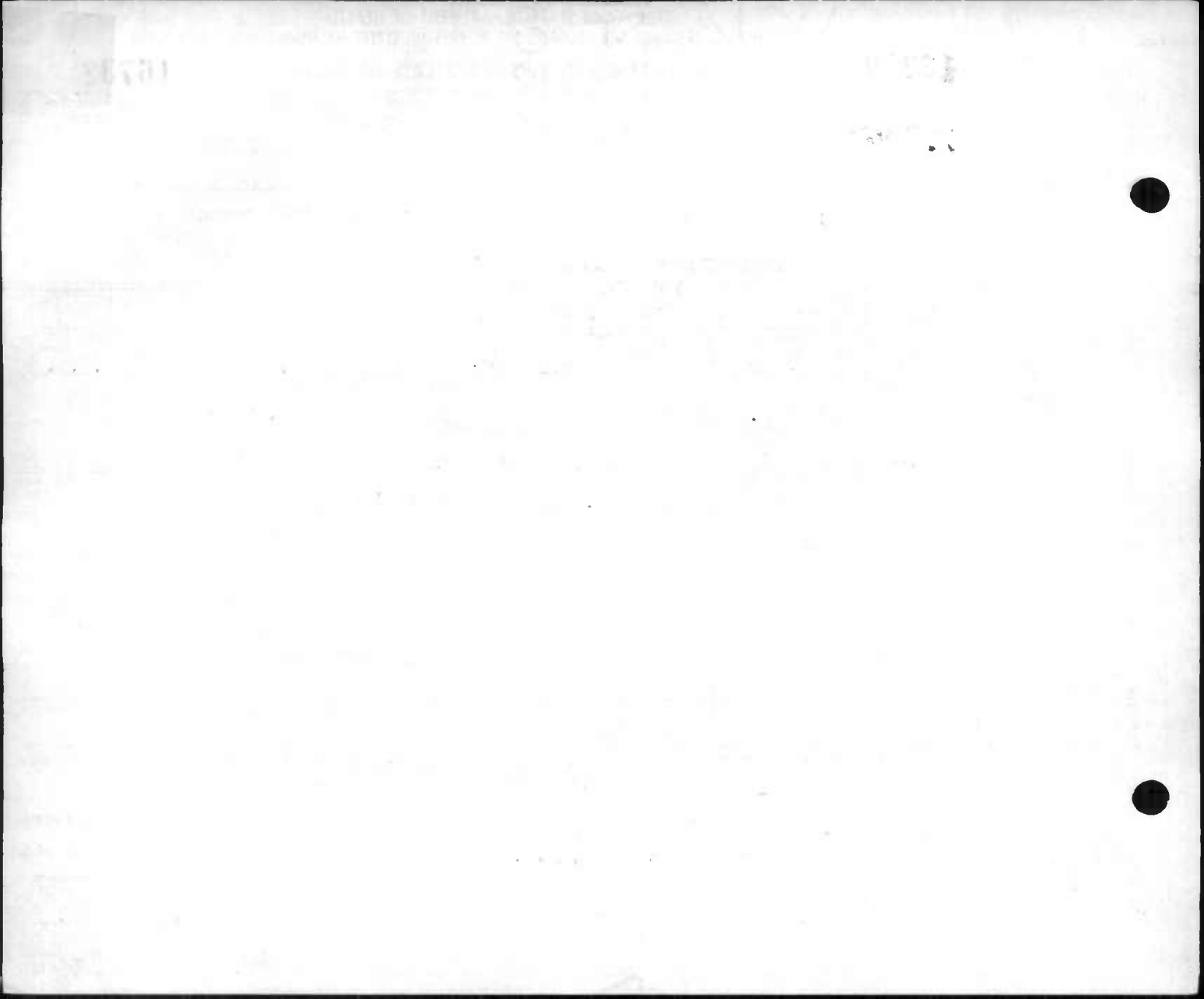
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16729

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16732

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8937 Carlisle Avenue</b>		d. STREET ADDRESS <b>8937 Carlisle Avenue</b> <b>36</b>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>ALLEN</b> Last <b>HERMAN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-1920</b>
9. AGE (In years lost, birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool &amp; Die Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Chemical Center</b>	
11. BIRTHPLACE (State or foreign country) <b>Abington Va..</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles L. Herman</b>		14. MOTHER'S MAIDEN NAME <b>Ada M. Rhea</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>214-12-2690</b>	
17. INFORMANT <b>Mrs Madalyn Herman</b>		Address <b>8937 Carlisle Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>		22. DATE SIGNED <b>12/28/66</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-31-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Have de Grace, Md.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
ADDRESS <b>7401 Belair Road 36</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16730					16733				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>					d. STREET ADDRESS <u>17 Aigburth Road</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Daisy Ascherfeld Herring</u>					4. DATE OF DEATH <u>December 10, 1966</u>				
5. SEX <u>Female</u>					8. DATE OF BIRTH <u>Jan. 27, 1887</u>				
6. COLOR OR RACE <u>White</u>					9. AGE (In years last birthday) <u>79</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Frederick A. Ascherfeld</u>					14. MOTHER'S MAIDEN NAME <u>Letitia Cousins</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Family records</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>70 yrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>64</u> , to <u>12-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Franklin E. Leslie</u>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Franklin E. Leslie, M.D.</u>					22d. ADDRESS <u>302 E. 33rd Street, Balto. Md. 21218</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Dec. 12, 1966</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>					25a. REC'D BY REGISTRAR <u>DEC 16 1966</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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1950-1951

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16731

16734

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN lb <b>5 Months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>203 Mysticwood Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>203 Mysticwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>August J. Herrmann</b>				<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>23</b> Year <b>19 66</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 1, 1903</b>							
<b>9. AGE</b> (In years last birthday) <b>63</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Post Office</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Erie, Pennsylvania</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <b>John Herrmann</b>									
<b>14. MOTHER'S MAIDEN NAME</b> <b>Eva Jungunst</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>									
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Mrs. Mary M. Herrmann, 203 Mysticwood Road</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema Obstructive</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Dec 1, 1966</b> , to <b>Dec 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 23, 1966</b> , and that death occurred at <b>1 P.M.</b> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <b>Manuel Levin</b>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>12/24/66</b>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Manuel Levin, M.D.</b>				<b>22d. ADDRESS</b> <b>4818 Reisterstown Road, Baltimore, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/27/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lake View Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Liberty Road, Carroll Co. Md.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>G. Vernon Lemmon</b>				<b>ADDRESS</b> <b>4611 Park Heights, Balto. Md.</b>		<b>25. REC'D BY REGISTRAR</b> <b>DATE</b>							
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Salisbury

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Salisbury

303 Westwood Road

303 Westwood Road

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August

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May 1, 1903

White

White

White, Pennsylvania

U.S. Post Office

Clerk

John Hermann

John Hermann

Mr. W. M. Hermann, 303 Westwood Road

to

*Handwritten notes and signatures*

*Handwritten signature*

1818 Salisbury Road, Salisbury, Md.

Manual Latin, W.D.

1818 Salisbury Road, Carroll Co., Md.

1818 Salisbury Road, Carroll Co., Md.

1818 Salisbury Road

1818 Salisbury Road

1818 Salisbury Road, Carroll Co., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16732

## CERTIFICATE OF DEATH

16735

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth25dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> <b>03.1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>			d. STREET ADDRESS <b>720 Maiden Choice Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sister Mary</b> Middle <b>Gabriel</b> Last <b>Higgins</b>			4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>1966</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887, Sept 1979</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious Sister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>	11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Wm. Higgins</b>			14. MOTHER'S MAIDEN NAME <b>Helen Lenahan</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>219-54-3106</b>	17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, right</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <del>(it)</del> (this hospital) attended the deceased from <b>Oct. 14, 1966</b> , to <b>Dec. 12, 1966</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>Dec. 12, 1966</b> , and that death occurred at <b>5:20</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>			22b. DATE SIGNED <b>12-12-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		
23b. DATE THEREOF <b>Dec 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dom. Sisters Perm. Rosary Catonsville, Md.</b>		23d. LOCATION (City or town) (County) (State) <b>20 Maiden Choice Lane Catonsville, Md.</b>	
24. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE 736 Edmondson Av. Catonsville, Md.</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			DATE <b>DEC 16 1966</b>		



18528

4631

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16733

## CERTIFICATE OF DEATH

16736

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings mill</u>				c. LENGTH OF STAY IN 1b <u>5 Mos. 25 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Hospital</u>				e. STREET ADDRESS <u>2218 Lyndhurst Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Alan Timothy Hill</u>				4. DATE OF DEATH <u>Dec. 25 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-65</u>	
9. AGE (In years last birthday) <u>11 yrs. 8 mos.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Welbon Hill Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Doris Neal</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. Weldon Hill Jr</u> Address <u>2218 Lynhurst Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> <u>340.1</u> DUE TO <u>Pneumococcal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>340.1</u> DUE TO (c) <u>terminal asperuison</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 30</u> , 19 <u>66</u> , to <u>Dec. 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 25</u> , 19 <u>66</u> , and that death occurred at <u>7:4M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Jones</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>26 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones M.D.</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Herbert E. Nutter</u> ADDRESS <u>3035 W. North Ave</u>				25a. REC'D BY REGISTRAR <u>JAN 4 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Management Committee

General Secretary

Richard D. Jones

Stated

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**16734** **CERTIFICATE OF DEATH** **16731**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>32 days</u>		c. CITY OR TOWN <u>Crisfield</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>268 Somerset Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward John Holland</u>		4. DATE OF DEATH Month Day Year <u>December 21 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George J. Holland</u>		14. MOTHER'S MAIDEN NAME <u>Blakes Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>127-14-8363</u>	
17. INFORMANT <u>Joyce Carey</u>		Address <u>116 Lakeview Drive Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of larynx</u> 161X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19</u> , 19 <u>66</u> , to <u>Dec. 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 21</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Ludivina M. Oteyza</u>		22b. DATE SIGNED <u>12/21/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LUDIVINA M. OTEYZA</u>		22d. ADDRESS <u>GBMC - N. Charles St., BALT. Md. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 24, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Crisfield, Md.</u>	
24. FUNERAL DIRECTOR <u>Sevens Park Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16735

CERTIFICATE OF DEATH

16735

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>27 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1643 N. MONROE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>OLIVER</b> Last <b>HOLLAND</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>DEC 1, 1921</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>LOUIS HOLLAND</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE CARROLL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>217 16 70 29</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA FROM CARCINOMA OF PENIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHOPNEUMONIA</b> (c) <b>PEPTIC ULCER</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>RECENT</b> <b>UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV 10</b> , 19 <b>66</b> , to <b>DEC 7</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 7</b> , 19 <b>66</b> , and that death occurred at <b>807P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph W. Kurad</b>		22b. DATE SIGNED <b>12-8-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH W. KURAD, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE-THEREOF <b>12/12/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>ARLINGTON S. PHILLIPS</b>		25a. REC'D BY REGISTRAR <b>FUNERAL HOME</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>DEC 12 1966</b>	

ADDRESS  
**ARLINGTON S. PHILLIPS**  
**1500 BLK N. MONROE ST. BALTIMORE, MD.**







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>				c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				<b>12.2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>						d. STREET ADDRESS <b>227 Edmund St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Warren</b>			<b>First</b>			<b>Middle</b>			<b>Last</b>		
<b>5. SEX</b> <b>M</b>			<b>6. COLOR OR RACE</b> <b>W</b>			<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>11.13.83</b>		
<b>9. AGE</b> (In years last birthday) <b>83 yrs.</b>			<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Tilesetter</b>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		
<b>13. FATHER'S NAME</b> <b>Emma John Holmes</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Folks</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)						<b>16. SOCIAL SECURITY NO.</b> <b>217-01-3007</b>			<b>17. INFORMANT</b> <b>Records, Mt. Wilson State Hospital</b>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Pulmonary Embolism</b> <b>466X</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>(b) Phlebotrombosis of prostatic</b> <b>(c) Pleuro</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>002.1 Chronic pulmonary Tuberculosis.</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
				<b>20f. (City or town)</b>				<b>(County)</b>			
				<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11.22, 1966</b> , <b>to</b> <b>12.16, 1966</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>12.16, 1966</b> , <b>and that death occurred at</b> <b>9:55 P.</b> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Wm. Newcomer</b>						<b>22b. DATE SIGNED</b> <b>11.17.66</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>						<b>22d. ADDRESS</b> <b>Mt. Wilson, Maryland</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>12-20-1966</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>			
				<b>23d. LOCATION (City, town or county)</b> <b>Baltimore</b>				<b>(State)</b> <b>Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Lassahn Funeral Home 7401 Belair Road</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 21 1966</b>					
						<b>25b. REGISTRAR'S SIGNATURE</b> <b>[Signature]</b>					

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Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Mr. Bowdoin, M.D., Superintendent

Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

16737

CERTIFICATE OF DEATH

16740

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>11 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>18 East Montgomery St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Audrey</b> Middle <b>Gray</b> Last <b>HOPKINS</b>		4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-54</b>
9. AGE (In years lost birthday) <b>12 yrs.</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>22</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Johnny Allen</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Ann Shortt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no --</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Broncho.</b> DUE TO (b) <b>Bronchitis, acute.</b> DUE TO (c) <b>14 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>16 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Cong. Hydrocephalus with the symptomatic Epilepsy &amp; grand mal fits</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>p.m.</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that <del>to</del> (this hospital) attended the deceased from <b>10-6</b> , 19 <b>55</b> , to <b>12-22</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>12-22</b> 19 <b>66</b> , and that death occurred at <b>2:00 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Harry G. Butler</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/24/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Attorney Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Manion VA.</b>	
24. FUNERAL DIRECTOR <b>J.F. Elin &amp; Sons Reisterstown Md</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TESTIMONY OF

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*[Faint, mostly illegible text from a document, possibly a transcript or report. Some words like "testimony" and "of" are visible.]*

THE ATTORNEY GENERAL  
OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D.C.

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and bury event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16738

16741

1. PLACE OF DEATH a. COUNTY <u>Towson</u> <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> <u>TOWSON</u> - <u>4</u>			c. LENGTH OF STAY IN 1b <u>4</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>			d. STREET ADDRESS <u>6 St. Michaels Way</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>E.</u> Last <u>Horka</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-16</u> <u>1918</u>	9. AGE (In years last birthday) <u>48</u> <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leon S. Horka</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Belbot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-05-2183</u>		17. INFORMANT <u>Mrs. Marie T. Horka</u> Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Baltimore</u>	(County) <u>  </u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>12/4/66</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		Address (Street, city, town, or county) <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/7/66.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	
23d. LOCATION (City or Town) <u>Baltimore, Md.</u>		(County) <u>  </u> (State) <u>  </u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		ADDRESS <u>  </u>		25a. REC'D BY REGISTRAR DATE <u>DEC 6</u> 19 <u>66</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16742

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb <b>NOV. 1962</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1000 EDMONDSON AVE #28</b>		d. STREET ADDRESS <b>1000 EDMONDSON AVE #28</b>	
3. NAME OF DECEASED (Type or print) <b>MARION ESTELLE HORN</b>		4. DATE OF DEATH <b>DEC 12 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/1892</b>
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Philadelphia Pa</b>	
11. FATHER'S NAME <b>WILLIAM E. McCABE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>MRS. FLORENCE RESTIVO</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HAS VD</b> <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL HEMORRHAGE</b> (c) <b>MANIC DEPRESSIVE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>~10 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. Kasaitis M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. KASAITIS M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>12/12/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-15-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gruid Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Edw. S. Mac Millan - 301 Frederick Rd - 28</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16740

CERTIFICATE OF DEATH

18066

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>81 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GALESVILLE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS - - - - -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLIS SAMUEL HOWES</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 22 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 27, 1892</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sea Food</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CHURCHTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT F. HOWES</b>				14. MOTHER'S MAIDEN NAME <b>VERDA V. TROH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>216 18 57 32</b>		17. INFORMANT <b>CLINICAL RECORDS VA HOSPITAL, FT. HOWARD</b> Address <b>MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CIRRHOSIS OF LIVER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>OCT 2</b> , 19 <b>66</b> , to <b>DEC 22</b> , 19 <b>66</b> that (1) (we) last saw the deceased alive on <b>DEC. 22</b> , 19 <b>66</b> , and that death occurred at <b>620PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Dobson</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M.D.</b>				22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FRIENDSHIP CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>FRIENDSHIP, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>BERNARD O. HARDESTY</b> ADDRESS <b>GALESVILLE, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 12 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16741

**CERTIFICATE OF DEATH**

16743

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>18 Willow Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Mae C. HUBBARD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>66</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-82</b>	
9. AGE (In years lost birthday) <b>84 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Telephone Operator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin M. Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mullan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-3249</b>		17. INFORMANT <b>John Carroll Dunn</b> Address <b>4102 Klausmeir Rd. - 21236</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 29, 1966</b> , to <b>Dec. 29, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 29, 1966</b> , and that death occurred at <b>7:55 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Manuel S. Cockburn</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Manuel S. Cockburn, M.D.</b>				22d. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Saint Joseph's Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Fullerton, Md.</b>	
24. FUNERAL DIRECTOR <b>John C. Miller Inc. - 6415 Belair Road - 21206</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10114

EXHIBIT 10114

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EXHIBIT 10114

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EXHIBIT 10114

EXHIBIT 10114

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16742

16744

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>221 EASTERN AVE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> d. STREET ADDRESS <u>221 EASTERN AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>NEELY</u> First <u>R.</u> Middle <u>HURLEY</u> Last		<b>4. DATE OF DEATH</b> Month <u>DEC</u> Day <u>3</u> Year <u>1966</u>		9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/97</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WM. R. HURLEY</u>			14. MOTHER'S MAIDEN NAME <u>MAMIE SMITH</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-1046</u>	17. INFORMANT Address <u>MELVIN HURLEY</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN.</u>  <u>2 YRS.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 2</u> , 19 <u>60</u> , to <u>DEC 3</u> , 1966, that (I) (we) last saw the deceased alive on <u>DEC 2</u> 1966, and that death occurred at <u>226 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Miceli</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>  </u>		22b. DATE SIGNED <u>12/5/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MICELI M.D.</u>			22d. ADDRESS <u>108 S. TAYLOR AVE</u> <u>ESSEX, MD. 21221</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/6/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORELANDS</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD.</u>			
24. FUNERAL DIRECTOR <u>J. C. CONNELLY</u> ADDRESS <u>300 MACE</u>			25a. REC'D BY REGISTRAR <u>DEC 7</u> 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10744

RECORDS OF DEATH

10744

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DEPT. OF HEALTH  
RECORDS OF DEATH  
10744



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16743

16745

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mercy Villa</b>		e. STREET ADDRESS <b>Old County Road Box 18</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ursula</b>		First <b>Helen</b>		Middle <b>Hurt</b>		Last <b>Hurt</b>	
4. DATE OF DEATH <b>December 23, 1966</b>		Month <b>December</b>		Day <b>23</b>		Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 25, 1888</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Min. <b>78</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Casey</b>		14. MOTHER'S MAIDEN NAME <b>Martha Powers McIntyre</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>Casey</b>		17. INFORMANT <b>Mrs. Joseph Sheehan</b>		18. ADDRESS <b>Old County Road Box 18 Severna Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> DUE TO (c) <b>422.1</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-1</b> , 19 <b>66</b> , to <b>12-23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-17</b> , 19 <b>66</b> , and that death occurred at <b>12-23</b> , 19 <b>66</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip D. Flynn</b>		22b. DATE SIGNED <b>12-27-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Philip D. Flynn</b>		22d. ADDRESS <b>11 E. Chase St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. F. Tinker</b>		24a. ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10348

10348



*[Faint, mostly illegible text and markings covering the lower two-thirds of the page. Some words like "Library" and "Collection" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16744

16746

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>5 yrs 2 mths 9 d</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>		d. STREET ADDRESS <u>1713 William Street</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Unhoff</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-83</u>
9. AGE (In years, last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Matthew Unhoff</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Leidlich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Spring Grove State Hosp. records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 30, 1966</u> to <u>Dec. 10, 1966</u> that (I) (we) last saw the deceased alive on <u>Dec. 10, 1966</u> , and that death occurred at <u>11:53</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. Smeets</u>		22b. DATE SIGNED <u>Dec. 11, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Smeets</u>		22d. ADDRESS <u>Spring Grove State Hospital, Catonsville, Maryland 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12 15 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Brooklyn, A. A. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Mc Cully</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 13 1966</u>	
ADDRESS <u>130 E. Fort Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

10446

RECORD OF DEEDS

10446

[Faint, illegible text throughout the page, likely bleed-through from the reverse side. The text appears to be organized into sections, possibly containing names, dates, and descriptions of property or transactions.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16745

CERTIFICATE OF DEATH

16747

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Towson</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>		d. STREET ADDRESS <b>409 Schwartz Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>L.</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>28</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 14, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Garoway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Walter Mack</b>		Address <b>726 Bisley Ave Towson</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>bilateral ureteral obstruction by malignant tumor of urinary bladder.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 21, 19 66</b> , to <b>December 28, 19 66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 28, 19 66</b> , and that death occurred at <b>5:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>12/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/31/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Rest</b>	23d. LOCATION (City or Town) (County) (State) <b>Towson, Balto. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Wm. L. Chatman</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
ADDRESS <b>1701 M &amp; Guilford St. Baltimore</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16746

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16748

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>N. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 wk.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lake Toxaway</b>		70.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>Eastshore Dr.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Gilpen Johnston</b>		4. DATE OF DEATH Month Day Year <b>Dec. 26, 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-26-1896</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grain Broker</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Farming.</b>	
11. BIRTHPLACE (State or foreign country) <b>Prairieton, Town Ship Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>James H. Johnston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Drake</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Eastshore Dr.</b> <b>Marie Johnston, Lake Toxaway, N.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>12/26/66</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-29-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Prairieton Town Ship, Ind.</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>		ADDRESS <b>Towson, Md. 21204</b>	
25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16747

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16749

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RIDGEWAY MANOR NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLOTTE E. JONES</b>		4. DATE OF DEATH <b>12/26</b> 19 <b>66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1886</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE SCHOENFELDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HELEN AKERS</b> Address <b>52 MELLER AVE, BALTO - 28</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIO SCLEROTIC</b> DUE TO <b>CARDIO VASCULAR DISEASE</b> (b) <b>PARKINSONS DISEASE</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NONE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edmund Kasaitis</b> M.D.		22. DATE SIGNED <b>12/26/66</b>	
EXAMINER'S NAME (Type) <b>EDMUND KASAITIS, M.D.</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/29/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO MD</b>
24. FUNERAL DIRECTOR <b>E.S. MACNAB</b> 301 FREDERICK RD 21228		25. REC'D BY REGISTRAR <b>DEC 27 1966</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16748 CERTIFICATE OF DEATH 16750

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN ID <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4034 Haywood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jositis, GRACE B.</u> First Middle Last		4. DATE OF DEATH <u>Dec 23, 1966</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-92 (74) 73</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Companion</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Families</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>Edward Burns</u>		14. MOTHER'S MAIDEN NAME <u>Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-34-7936</u>	17. INFORMANT <u>Pts. Chart.</u> Address
18. CAUSE OF DEATH [Enter only one cause per line, (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GRAM-NEGATIVE SEPSIS</u> 2041 DUE TO <u>Chronic myelogenous leukemia</u> 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>WITH MARROW FAILURE</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 4, 1966</u> , to <u>DEC 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>DEC 23, 1966</u> , and that death occurred at <u>9:50 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Manuel A. Gorgon</u> M.O.		22b. DATE SIGNED <u>DEC. 24, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL A. GORGON</u>		22d. ADDRESS <u>G-13MC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/27/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>B. Vernon Lemmon</u> ADDRESS <u>4611 Park Heights Ave. Balto.</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Corruption Private Parties Baltimore, Md.

Charles Thompson

WALTER A. GORDON

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FOR STATE  
HEALTH DEPT.

16749

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16751

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>30.4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6100 Block Frederick Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1310 Harlem Road Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carey JOWERS</b> First Middle Last 4. DATE OF DEATH <b>December 22, 19 66</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11-16-32</b> 9. AGE (In years last birthday) <b>34</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bulldozer Operator</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b> 11. BIRTHPLACE (State or foreign country) <b>Jefferson, S. C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Luther Jowers</b> 14. MOTHER'S MAIDEN NAME <b>Geneva ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>Georgia Jowers - 1310 Harlem Ave.</b> 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>910.8</b> IMMEDIATE CAUSE (a) <b>Cerebrocranial injuries</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>about 3:50 p.m. 12-22 1966</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tearing down old house &amp; crushed by falling stairs</b> 20c. TIME OF INJURY Month, Day, Year <b>3:50 p.m. 12-22 1966</b> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>house</b> 20f. (City or town) (County) (State) <b>Baltimore, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Noturol causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined monner</b> <input type="checkbox"/> 22. DATE SIGNED <b>December 27, 1966</b>		ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12-28-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR <b>Charles R. Law 802 Madison Ave., Balto, Md.</b> 25a. REC'D BY REGISTRAR <b>DEC 29 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

16752

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21204</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>610 Coventry Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>R. Norman Joyner</b>				4. DATE OF DEATH Month Day Year <b>Dec. 28 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-98</b>		9. AGE (In years lost birthday) <b>68 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Security Insurance Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Julius S. Joyner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Buschman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes WW I</b>		16. SOCIAL SECURITY NO. <b>212-07-0590</b>		17. INFORMANT Address <b>Mrs. Winifred J. Joyner 610 Coventry Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aneurysm</b> 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 28 1966</b> , to <b>Dec. 28 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28 1966</b> , and that death occurred at <b>11:30 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>M. Melencio Ventura</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Dec. 28 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. Melencio Ventura M.D.</b>				22d. ADDRESS <b>7620 York Road -Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>12/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Cty. Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16751

CERTIFICATE OF DEATH

16753

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>--</b> Last <b>KATES</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/84</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BAHAMAS ISLANDS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNK</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>215 07 59 38</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>491X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE. CONGESTIVE HEART FAILURE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>12/2/66</b> , 19 <b>12/8/66</b> , that (X) (we) last saw the deceased alive on <b>12/8/66</b> , 19 <b>19</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.		22b. DATE SIGNED <b>12/8/66</b>	
22a. SIGNATURE <i>Jorge A. Fabara</i>		22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22e. REC'D BY REGISTRAR <b>1966</b>	
22f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		22g. REGISTRAR'S NAME <b>CHARLES JUDGE</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Joseph N. Zannino, Jr.</i>		25. ADDRESS <b>ZANNINO FUNERAL HOME</b>	
25a. DATE <b>DEC 9 1966</b>		25b. ADDRESS <b>257 S. Conkling St. Baltimore, Md.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MALIBU

MALIBU

PORT HOWARD

8 DAYS

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4325 N. HORTON STREET

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BARBARA LIVING

U.S.A.

YES

NO

PROHIBITION

PROHIBITION

ARCHAEOLOGICAL RESEARCH. CONSERVATION RESEARCH

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JAMES A. WATSON, JR. D. VAN PORT HOWARD, MARYLAND

JAMES A. WATSON, JR. D. VAN PORT HOWARD, MARYLAND

JAMES A. WATSON, JR. D. VAN PORT HOWARD, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16752

CERTIFICATE OF DEATH

16754

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>03/1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE HOSPITAL</u>		d. STREET ADDRESS <u>5534 WILLYS AVE BALT</u>	
3. NAME OF DECEASED (Type or print) <u>FLORENCE M. KELLER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-84</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>FREDERICK Runge</u>		16. MOTHER'S MAIDEN NAME <u>ANNIE Morrison</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>unknown</u>		18. SOCIAL SECURITY NO. <u>unknown</u>	
19. INFORMANT <u>RECORDS SPRING GROVE HOSP</u>		Address	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE &amp; FIBRILLATION</u> (c) <u>GENERALISED ARTERIO SCLEROSIS SEVERE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-27-66</u> , 19 <u>66</u> , to <u>12-30-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-30-</u> , 19 <u>66</u> , and that death occurred at <u>6-15P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Emilio A. Trujillo M.D.</u> M.D.		22b. DATE SIGNED <u>DEC 31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EMILIO A. TRUJILLO M.D.</u>		22d. ADDRESS <u>Spring Grove State Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Freeland, Maryland</u>
24. FUNERAL DIRECTOR <u>Cambria Inc. 1328 Sulphur Sp. Rd.</u>		25. REC'D BY REGISTRAR DATE <u>JAN 3, 1967</u>	
25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

4501

25731



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16755

FOR STATE HEALTH DEPT.

16753

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manor Rd. near Sweet Air Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manor Rd. near Sweet Air Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Manor Road near Sweet Air Rd.</b>		d. STREET ADDRESS <b>Manor Rd. near Sweet Air Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Kelly</b> Last <b>Kelly</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2, 1911</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Labor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-6046</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles J. Donnell</b>		22. DATE SIGNED <b>12/31/66</b>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 3, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>May's Chapel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Lutherville, Md.</b>
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16754					16756					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3506 Round Hollow Road</u>					d. STREET ADDRESS <u>3506 Round Hollow Road</u>					
3. NAME OF DECEASED (Type or print) <u>Albert Kerbel</u>					4. DATE OF DEATH <u>December 13, 1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 7, 1909</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Max Kerbel</u>					14. MOTHER'S MAIDEN NAME <u>Dora Glazer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>M's. De Neice Kerbel</u> Address <u>3506 Round Hollow Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> <u>420.1</u> DUE TO <u>Ac Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic C.U.H.D.</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this <del>hospital</del> ) attended the deceased from <u>Mar 24, 1945</u> to <u>Dec 13, 1966</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Dec 13, 1966</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Willard Applefeld</u>					22b. DATE SIGNED <u>12/14/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Willard Applefeld</u>			
22d. ADDRESS <u>Park Heights &amp; Menlo Drive</u>					22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>					25a. REC'D BY REGISTRAR <u>DEC 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

32501

2531

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/66

16755

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16757

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. HOWARD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FT. HOWARD</u> <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FT HOWARD</u>		d. STREET ADDRESS <u>F. HOWARD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PETER</u> Middle <u>V.</u> Last <u>KESTRANEK</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>JUNE 29, 1880</u> 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT</u>	9. AGE (In years last birthday) yrs. <u>86</u>
11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>		14. MOTHER'S MAIDEN NAME <u>UNK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-22-0218</u>	17. INFORMANT <u>A.R. HOLMES</u> Address <u>807 N. WOODLYNN</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>974X</u> IMMEDIATE CAUSE (a) <u>STRANGULATION by HANGING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			INTERVAL BETWEEN ONSET AND DEATH <u>✓</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self from closet pole</u>	
20c. TIME OF INJURY, Month, Day, Year <u>7</u> a.m. <u>1</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>FT. HOWARD BALTO MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.		22. DATE SIGNED <u>12/17/66</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town) (County) (State) <u>6800 MONTGOMERY BLVD - Pikesville MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>JG CONNELLY SONS</u> ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

10751

10752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16756

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16758

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>House in the Pines</b>		d. STREET ADDRESS <b>6308 Holly Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FRANCIS</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1882</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brown King</b>		14. MOTHER'S MAIDEN NAME <b>Leila Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-01-5924A</b>	
17. INFORMANT <b>Mrs. Vernie H. King,</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>&gt; 10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> , 19 <b>62</b> , to <b>12/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/22</b> 19 <b>66</b> , and that death occurred at <b>12/29</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W. K. Gallagher, Jr.</b>		22b. DATE SIGNED <b>30 Dec 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. K. Gallagher, Jr., M. D.</b>		22d. ADDRESS <b>6630 Baltimore National Pike 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/31/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. <b>Woodlawn</b> (City or town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks, Inc. 1217 St. Paul Street</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 3 1967</b>	
ADDRESS <b>Baltimore 2, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10325

10325



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
16757 CERTIFICATE OF DEATH 16759															
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Reynolds Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3012 Gibbons Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Joseph John Kinlein</b> First Middle Last 4. DATE OF DEATH <b>Dec. 30 1966</b> Month Day Year						5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 18, 1884</b> 9. AGE (In years last birthday) <b>82</b> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant Retired</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>						11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Kinlein</b>						14. MOTHER'S MAIDEN NAME <b>Dorothea Stengel</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <b>16757</b>						17. INFORMANT <b>Mrs. Mary L. Kinlein</b> Address <b>(Same)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial + Cerebrovascular Insufficiency</b> <b>422.1</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>66</b> to <b>Dec</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 20</b> 19 <b>66</b> , and that death occurred at <b>2:42</b> AM, from the causes and on the date stated above.															
22a. SIGNATURE <b>William A. Tyson</b>						22b. DATE SIGNED <b>12-30-66</b>									
22c. PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>						22d. ADDRESS <b>Kingsville Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/3/66.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Balto. Md. 21214</b>						25a. REC'D BY REGISTRAR <b>JAN 4 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16758 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>7 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospice</b>					2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2239 East Chase St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Josephine Gertrude</b>			First <b>Josephine</b>		Middle <b>Gertrude</b>		Last <b>Knopp</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-27-1884</b>		9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>82</b> Days <b>28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Michael J. Curtin</b>						14. MOTHER'S MAIDEN NAME <b>Bridget Ann Martin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-52-2414</b>		17. INFORMANT <b>Hospice records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Ascend.</b> (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 30, 59</b> , 19....., to <b>Dec 28 66</b> , 19....., that (I) (we) last saw the deceased alive on <b>Dec. 27, 66</b> , 19....., and that death occurred <b>3.50 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert J. Mahon</b>						M.D. <b>Dec. 28, 1966</b>		22b. DATE SIGNED <b>Dec. 28, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert J. MAHON, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>			23d. LOCATION (City, town or county) <b>Cambridge Maryland</b>		
24 FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook &amp; Brooks</b>						ADDRESS <b>Towson, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MINISTRE OF HEALTH

Robert E. Griffin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Armecost Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> d. STREET ADDRESS <b>300 Stevenson Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Gladys H. Kohles</b>			First Middle Last		4. DATE OF DEATH <b>Dec. 10 19 66</b>		Month Day Year		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/1905</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George P. Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Malone</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-6888</b>		17. INFORMANT <b>Henry J. Kohles</b>		Address <b>(Same)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung &amp; Breast</b> DUE TO (b) <b>of Lung &amp; Breast</b> DUE TO (c) <b>Metastatic Carcinoma of Breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>12/12/66</b> to <b>12/12/66</b> , that (I) (we) last saw the deceased alive on <b>12/9/66</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles F. O'Donnell</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/12/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Charles F. O'Donnell</b>				22d. ADDRESS <b>7501 York Road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons</b>				ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10351

10351

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "of" are faintly visible.]*



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16760

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16762

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>D.O.A.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rawlings</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>		d. STREET ADDRESS <b>R.F.D. Route 3</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Margaret Virginia Kohne</b>		4. DATE OF DEATH <b>Dec. 17 1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1916</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11. BIRTHPLACE (State or foreign country) <b>McCool, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Claude G. Miers</b>	
14. MOTHER'S MAIDEN NAME <b>Julia Mae VanPelt</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>214-07-6549</b>		17. INFORMANT <b>Mrs. Beverly J. Martinski, 7442 Berkshire Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		22. DATE SIGNED <b>12-17-66</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		6 Hanover Rd., <b>Redsterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 21, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dawson Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Dawson, Md.</b>
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		25a. REC'D BY REGISTRAR <b>Lykowitz, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 21 1966</b>	



18782

18780

Baltimore

San Francisco

Baltimore, Md. 12-17-55

Dec. 17, 1955

White, J. 12-17-55

Washington, D.C. 12-17-55

Washington, D.C. 12-17-55

Washington, D.C. 12-17-55

Washington, D.C. 12-17-55

Washington, D.C. 12-17-55

none

none

Dec. 17, 1955

Dec. 17, 1955

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16761

CERTIFICATE OF DEATH

16763

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Balto. Maryland</b> b. COUNTY <b>5306 Wesley Avenue</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown, Md. Baltimore 30-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hill Chapel Nursing Home Liberty Road</b>		d. STREET ADDRESS <b>5306 Wesley Ave. Liberty Road</b>	
3. NAME OF DECEASED (Type or print) <b>Ferdinand Robert Krauss Sr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1884</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b> Hours <b>2</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman Retired</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Krauss (L)</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hoffman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-2907</b>	
17. INFORMANT <b>Lillian F. Krauss</b>		Address <b>5306 Wesley Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 (1) Arterio-sclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(5) Recurrent cerebral Thrombosis</b> DUE TO (c) <b>Broncho - Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs. 2 wks. 2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arterio Sclerosis &amp; Sensitivity</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 11, 1966</b> , to <b>Dec. 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18, 1966</b> , and that death occurred at <b>3 P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>12/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4108 Liberty Heights Avenue</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec 21, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10303

RECORD OF DEATH

10303

THE RECORD OF DEATHS IS A SUMMARY OF THE DEATHS WHICH HAVE OCCURRED IN THE DISTRICT OF COLUMBIA SINCE JANUARY 1, 1900. IT IS A SUMMARY OF THE DEATHS WHICH HAVE OCCURRED IN THE DISTRICT OF COLUMBIA SINCE JANUARY 1, 1900.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sikesville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3508 Maple Drive</u> 30.4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>-</u> Last <u>Kravitz</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/4</u>		9. AGE (In years last birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Katz</u>					14. MOTHER'S MAIDEN NAME <u>Miriam ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Doris A. Kravitz</u> Address <u>-2508 Wetherburn Rd</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Bladder</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Dec 31</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Dec 31</u> , 19 <u>66</u> , and that death occurred at <u>11:35</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Leon E. Kassel</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>LEON E. KASSEL</u>					22d. ADDRESS <u>2501 ST. PAUL STREET</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>JAN. 2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ariz Chaym</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR <u>Sal Leunon &amp; Bros</u>			ADDRESS <u>6010 Reisterstown Rd</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16763						16765					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Balto. MARYLAND			a. STATE			Md. b. COUNTY Balto		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Overlea			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Overlea		
c. LENGTH OF STAY IN 1b			40 yrs.			d. STREET ADDRESS			18 Madeline Ave		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			18 Madeline Ave			e. IS RESIDENCE ON A FARM?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Marine (Marr) E. Kroupa						Dec 19 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
F.		W.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 14, 1885		81 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
At Home			None			Balto. Md.			U.S.A.		
13. FATHER'S NAME			Hillebrand			14. MOTHER'S MAIDEN NAME			Sahm		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFIRMANT			Address		
NO			None			Ferdinand A. Kroupa Sr.			18 Madeline Ave		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										2 mos	
181.0 DUE TO (b) Urinary Bladder - Carcinoma											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)										19. WAS AUTOPSY PERFORMED?	
Arteriosclerotic Vascular disease.										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from Aug, 1966 to Dec, 1966, that (I) (we) last saw the deceased alive on Dec 19, 1966, and that death occurred at 5 PM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
Frank T. Kasik Jr.											
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
FRANK T. KASIK JR.						9005 HARFORD RD. BALTO. MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			Dec. 5-66			Garden of Faithful			Trumps Mill Rd. Balto. Co. Md.		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Nippel Bros Inc. 7112 Belair Rd.						DATE DEC 5 1966			J. Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16764

CERTIFICATE OF DEATH

16766

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #6</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2810 Taylor Ave.</u>		d. STREET ADDRESS <u>1233 Primrose Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Krucky</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1894.</u>
9. AGE (In years and months) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Macko</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Sindelar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-30-3024D</u>	
17. INFORMANT <u>Mr. W. G. Macko</u>		Address <u>6506 Glenoak Ave. #14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary-vascular vessel dis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>June 19 57</u> to <u>Dec 28, 19 66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28 19 66</u> , and that death occurred at <u>10 04</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. Bacon</u>		22b. DATE SIGNED <u>12/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		22d. ADDRESS <u>2810 Taylor Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/31/66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16765

16767

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Baltimore City Genl Hospital</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>031</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore</u>		d. STREET ADDRESS <u>3524 St. James Rd</u>	
3. NAME OF DECEASED (Type or print) <u>William W. Lake</u>		4. DATE OF DEATH Month <u>12</u> - Day <u>9</u> - Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-04</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Heat &amp; Power Corp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Wm. Lake</u>	
14. MOTHER'S MAIDEN NAME <u>Fannie Estep</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.2</u>	
16. SOCIAL SECURITY NO. <u>215-12-8147</u>		17. INFORMANT Address <u>Mrs. Goldie A. Weber 3524 St. James Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <u>163X</u> IMMEDIATE CAUSE (a) <u>C.A. of the lung &amp; generalized</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-8-1965</u> , to <u>12-9-1966</u> that (I) (we) last saw the deceased alive on <u>12-9-1966</u> , and that death occurred at <u>8:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Pavaero</u>		22b. DATE SIGNED <u>12-9-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE PAVERO</u>		22d. ADDRESS <u>8629 Liberty Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL-Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-13-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>
24. FUNERAL DIRECTOR <u>Howard Strong 307 W. North Ave</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*

RECEIVED BY THE COUNTY CLERK OF THE COUNTY OF ...  
ON THE ... DAY OF ... 19...  
AT ...

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

16766

16768

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 03.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>924 Dunellen Road</b>				d. STREET ADDRESS <b>924 Dunellen Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Joseph</b> Last <b>Lane</b>				4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1880</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Waste</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas L. Lane</b>				14. MOTHER'S MAIDEN NAME <b>Alice Doran</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>017 26 0552</b>		17. INFORMANT <b>Walter J. Lane</b> Address <b>924 Dunellen Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Coronary Insufficiency</b> (c) <b>Cardiac Decongestion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles J. Judge</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>1729/66</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Mt. Calvary Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Boston Mass.</b>	
24. FUNERAL DIRECTOR <b>John E. Johnson</b> ADDRESS <b>8521 Kenilworth</b>				25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16767

## CERTIFICATE OF DEATH

16769

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		d. STREET ADDRESS <b>106 West Elm Ave. 21206</b>	
3. NAME OF DECEASED (Type or print) <b>Henry Rothauge</b> First Middle Last		4. DATE OF DEATH <b>December 24 19 66</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1912</b> 54 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Laucht</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WW2</b>		16. SOCIAL SECURITY NO. <b>212-01-6888</b>	
17. INFORMANT <b>Mrs. Lillian M. Laucht</b> Address <b>(Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 24, 1966</b> , to <b>December 24 66</b> that (I) (we) last saw the deceased alive on <b>December 24 19 66</b> , and that death occurred at <b>6:45 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Nelson A. Villamor</b>		22b. DATE SIGNED <b>December 24, 19 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Nelson A. Villamor M.D.</b>		22d. ADDRESS <b>7620 York Rd. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE THEREOF <b>12/28/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b> ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b> DATE	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16768

CERTIFICATE OF DEATH

16770

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>				d. STREET ADDRESS <b>Elkton, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Michael</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>19 66</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 3, 1904</b>		9. AGE (In years last birthday) <b>62</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Perryman, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Lee</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Kehoe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-22-4413</b>		17. INFORMANT Address <b>Mrs. Anne Lee Weber, Edgewood, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>422.1</b> DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Post cholecystectomy - 12-28-66</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>December 22 1966</b> , to <b>December 31 1966</b> , that <b>he</b> (we) last saw the deceased alive on <b>December 31 19 66</b> , and that death occurred at <b>6:05 am</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Manuel S. Cockburn M.D.</i>				22b. DATE SIGNED <b>December 31, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Manuel S. Cockburn, M. D.</b>	
22d. ADDRESS <b>7620 York Road, Towson 4, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Perryman Harford Md</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18788

CERTIFICATE OF DEATH

18788

DECEASED

DATE OF DEATH - 12-1-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16769

16771

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> 03.1	
d. NAME OF PLACE OR INSTITUTION (If not in hospital, give street address) <u>7733 Bagley Ave</u>		d. STREET ADDRESS <u>7733 Bagley Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>H</u> Last <u>LOTTERER</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15 1880</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis to Georgia Nagedorn</u>		14. MOTHER'S MAIDEN NAME <u>Ernestine Kubatsky</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-NO-</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONIE</u>	
17. INFORMANT Address <u>Mrs Charlotte Fischer</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Woman</u> (b) <u>Chronic glomerulonephritis</u> (c) <u>Severe generalized atherosclerosis</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u> <u>15 yrs</u> <u>30 yrs</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1954</u> to <u>Dec, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec-19 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>12/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. MD</u>	
24. FUNERAL DIRECTOR <u>Chas. F. Evans &amp; Son</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10331

10331



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 12 Film G384 12/27/66 mh

16772

16770

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>919 Lutz Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ursula B. Lucas</b> Middle <b>and or Lukosevich</b> Last <b>Lukosevich</b>				4. DATE OF DEATH Month <b>December</b> Day <b>18</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Lithuania</b>	
13. FATHER'S NAME <b>Frank Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Stella Smith, 910 Courtney Rd. 21227</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure, acute (arteriosclerosis)</b> 260X DUE TO <b>Generalized arteriosclerosis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Diabetes</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b> <b>Several years</b> <b>Several years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 8, 1968</b> to <b>December 17, 1966</b> , that (I) <del>(we)</del> saw the deceased alive on <b>December 17, 1966</b> , and that death occurred at <b>11:50 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Eugene C. Baumann</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-19-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Eugene C. Baumann</b>				22d. ADDRESS <b>413 Eastern Avenue</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>				25a. REC'D BY REGISTRAR <b>DEC 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

10778

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
16771						16773							
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE COUNTY,</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CITY, MARYLAND</b>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Johnson - 4</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>512 Castle Drive</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES STANLEY MAGERSUPP</b>						4. DATE OF DEATH Month Day Year <b>12 11 1966</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/17/86</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>WILLIAM MAGERSUPP</b>						14. MOTHER'S MAIDEN NAME <b>HEISER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown -- no</b>				16. SOCIAL SECURITY NO. <b>213-10-2910</b>		17. INFORMANT <b>Mr. Stanley C. Magersupp</b>		Address <b>2315 Ravenview Rd</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the liver</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Carcinoma of the colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>November 12, 1966</b> , to <b>December 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 11, 1966</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Juan L. Roque</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-11-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>JUAN L. ROQUE</b>						22d. ADDRESS <b>6701 N. Charles St. Balto MD 4</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>						ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR <b>DEC 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
Balto., Md. 21212													

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WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16772 CERTIFICATE OF DEATH 16774

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>2 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Albion Hotel 900 Cathedral St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALAN</b> First <b>Wright</b> Middle <b>Mallam</b> Last 4. DATE OF DEATH <b>12 - 10</b> Month Day Year <b>1966</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>W.</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>7-31-87</b> 9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR Months Days Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b> 11. BIRTH PLACE (County & State, or foreign country) <b>Europe</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Mallam</b> 14. MOTHER'S MARDEN NAME <b>Rachel Paison</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> 16. SOCIAL SECURITY NO. <b>169-07 3592</b> 17. INFORMANT <b>Records, Mt. Wilson State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 002.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (if this hospital) attended the deceased from <b>11/22</b> , 19 <b>64</b> , to <b>12/10</b> , 19 <b>66</b> , that (if we) last saw the deceased alive on <b>12/10</b> , 19 <b>66</b> , and that death occurred at <b>6:20</b> M, from the causes and on the date stated above.				22a. SIGNATURE <b>W. Newcomer</b> 22b. DATE SIGNED <b>12/10/66</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland</b> 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Dec. 15, 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Md.</b> 23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>				24. FUNERAL DIRECTOR <b>Newell Funeral Home Pleasant - 8-1164</b> 25a. REC'D BY REGISTRAR <b>JAN 3 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

10773

10773

Delaware County

Mount Wilson

Mount Wilson State Hospital

1917

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Mount Wilson  
Delaware County

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Mount Wilson State Hospital

James M. Newcomer, M.D., Superintendent Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16773

CERTIFICATE OF DEATH

16775

1. PLACE OF DEATH a. COUNTRY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bandalls town</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>6103 Park Heights Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Conzentina</u> Middle <u>Maranto</u> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July-31-1892</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Coat Shop</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Late - Rosario Provenza</u>		14. MOTHER'S MAIDEN NAME <u>Late - Teresa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-3652A</u>	
17. INFORMANT <u>Mr. Paul Maranto</u> <u>6108 Park Heights Ave.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>10:45</u> P.M. from causes on <u>  </u> the date stated above.			
22a. SIGNATURE <u>Frank K. Patino</u>		22b. DATE SIGNED <u>12-24-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-28-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke F.D.-4101 Edmondson Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Richard J. ...</u>	

1333

1058



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16775

CERTIFICATE OF DEATH

16776

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>106 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1058 Argyle Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>H. A.</b> Last <b>MARTIN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>16</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/92</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MOVING COMPANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH H. MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH MITCHELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>215 10 08 87</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BACTERIEMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>9/1/66</b> , 19 to <b>12/16/66</b> , 19, that (1) (we) last saw the deceased alive on <b>12/16/66</b> , 19, and that death occurred at <b>10:20AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>12/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-20-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>[Signature]</i> <b>1348</b>		25a. REC'D BY REGISTRAR <b>DEC 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S NAME <b>N. CALHOUN STREET, BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16776

## CERTIFICATE OF DEATH

16777

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN 1b <b>30.4</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21213</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>				d. STREET ADDRESS <b>2826 Clifton Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Santa</b> Middle <b>DiMARTINO</b> or Last <b>MARTINI</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1966</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 2, 1884</b>	
9. AGE (In years lost birthday) yrs. <b>82</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>				13. FATHER'S NAME <b>Joseph Valenti</b>			
14. MOTHER'S MAIDEN NAME <b>Lucy Cianci</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Pasquale Martini, husband, above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4341 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 25 1966</b> , to <b>December 29 66</b> that (I) (we) last saw the deceased alive on <b>December 2 19 66</b> , and that death occurred at <b>2:10 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Teodulo Paglinawan</b>				22b. DATE SIGNED <b>December 2, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Teodulo Paglinawan M.D.</b>	
22d. ADDRESS <b>7620 York Rd. Towson 21204</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

*Stapman*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16777

## CERTIFICATE OF DEATH

16778

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> <span style="float: right;">03.1</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>HOWARD AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ANTONIO - - - - MARZOCCHI</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>DECEMBER 8 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 20, 1892</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>212 46 70 05</b>		17. INFORMANT <b>VA HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, MASSIVE</b> (b) <b>PULMONARY EDEMA</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>BENIGN PROSTATIC HYPERTROPHY</b>				INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>RECENT</b> <b>OLD</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>17</b> (this hospital) attended the deceased from <b>DEC 7</b> , 1966, to <b>DEC 8</b> , 1966, that <b>17</b> (we) last saw the deceased alive on <b>DEC 8</b> , 1966, and that death occurred at <b>715PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Lawrence F. Awalt Jr.</b> M.D.						22b. DATE SIGNED <b>12/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LAWRENCE F. AWALT, JR., M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec-12-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA</b>				ADDRESS <b>DUDA FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>	
<b>WISE AVENUE, BALTIMORE, MD.</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RICHARD AVENUE

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16778

## CERTIFICATE OF DEATH

Item #2b,c & d Film #G384 1/16/67 pc

16779

<b>1. PLACE OF DEATH</b> a. COUNTY Baltimore				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 9 months			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospice				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore /// 21210 / Cumberland			
<b>3. NAME OF DECEASED</b> (Type or print) Jane Cecelia Mattingly				<b>4. DATE OF DEATH</b> Month Day Year 12 27 19 66			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22 - 1876	
9. AGE (In years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		11. BIRTHPLACE (County & State, or foreign country) Mt. Savage, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Mattingly				14. MOTHER'S MAIDEN NAME Ellen Daily			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-44-3881			
17. INFORMANT Edward J. Mattingly 515 Greenway Ave. obtained from records Cumberland, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) severity (c) DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-8-66, 19, to 12/27/66, 19, that (I) (we) last saw the deceased alive on 12/27/66, 19, and that death occurred at 4P.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Mahon, M.D.				22b. DATE SIGNED 12/27/66			
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.				22d. ADDRESS 204 E. Joppa Rd. Towson			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 30, 1966		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEMETERY		23d. LOCATION (City, town or county) (State) MT. SAVAGE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Dale L. Merritt				25a. REC'D BY REGISTRAR DEC 30 1966			
ADDRESS 404 Decatur Street Cumberland, Md.				25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16779

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

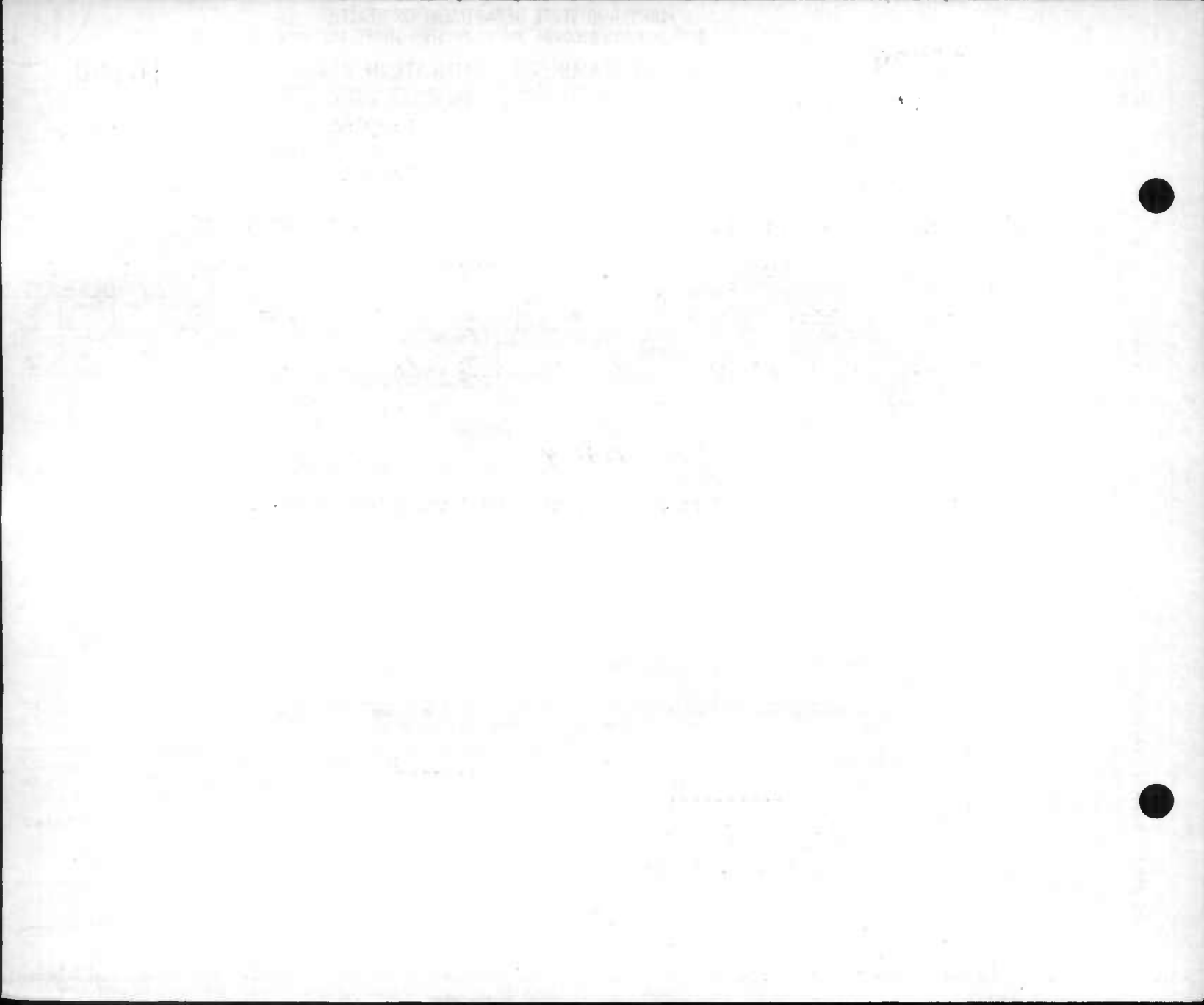
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>13.2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				e. STREET ADDRESS <b>Whiskey Bottom Road</b>			
3. NAME OF DECEASED (Type or print) First <b>OTH</b> Middle <b>D.</b> Last <b>MAYNARD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>7</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 24, 1902</b>	
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b> Hours <b>00</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Garrett</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Vaughan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO. <b>242 429348</b>		17. INFORMANT <b>Ruby Maynard, Laurel, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.				22. DATE SIGNED <b>12/8/66</b>			
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>				Address (Street, city, town, or county) <b>Laurel, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-12-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>W. W. Witte</b>				25a. REC'D BY REGISTRAR <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16780

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16781

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Dead on Arrival</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		e. STREET ADDRESS <b>901 Emerson Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>McCarthy</b> Last <b>McCarthy</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1895</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael McCarthy</b>		14. MOTHER'S MAIDEN NAME <b>Mary McDough</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>157-14-5288</b>	
17. INFORMANT <b>Mrs. Jamesina McCarthy</b>		Address <b>Same as 2d</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>295</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>12/26/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-30-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hillside, New Jersey</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16781

## CERTIFICATE OF DEATH

16782

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Baltimore</b>		c. LENGTH OF STAY IN 1b <b>5 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Augsburg Lutheran Home 6811 Campfield Road Balto Md 21207</b>		d. STREET ADDRESS <b>5911 Burgess Ave. 21214</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		30.4	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Bosley</b> Last <b>McComas</b>		4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/69</b>
9. AGE (In years last birthday) <b>97</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Shawsville, Harford Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua McComas</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca J. Maul</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-26-37621</b>	
17. INFORMANT <b>Paul A. Hauer</b>		Address <b>6811 Campfield Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epidermoid Carcinoma neck -</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Generalized Arterio Sclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 17, 1966</b> , to <b>Dec. 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 17, 1966</b> , and that death occurred at <b>9 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Chambers</b>		22b. DATE SIGNED <b>12/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers</b>		22d. ADDRESS <b>4108 Liberty St</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/24/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1638

32531

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16782

## CERTIFICATE OF DEATH

16783

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN lb <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> d. STREET ADDRESS <b>ARCADE BUILDING, MAIN STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CIAUDE WILLIAM MC DANIEL</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 3 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 10, 1903</b>
9. AGE (In years lost birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TELEPHONE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WORCESTER COUNTY, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRED MC DANIEL</b>		14. MOTHER'S MAIDEN NAME <b>LOLA MAE OUTTEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>214 10 67 10</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. ADDRESS <b>CLINICAL RECORDS FORT HOWARD, MARYLAND</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION AND EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>FATTY LIVER</b> DUE TO (c) <b>CHRONIC PANCREATITIS WITH CALCULI</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>DEC 2</b> , 19 <b>66</b> , to <b>DEC 3</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>DEC 3</b> , 19 <b>66</b> , and that death occurred at <b>820P M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED <b>12 5 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-8-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SALEM METHODIST CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>POCOMOKE CITY, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>		25a. REC'D BY REGISTRAR <b>DEC 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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D. N. KAYNE, V. ZHIGACHEV

UNCLASSIFIED//FOR OFFICIAL USE ONLY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16783

CERTIFICATE OF DEATH

16784

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANN ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1611 SPRUCE STREET</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>OWEN - - - MC DANIEL</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 17 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 6, 1910</b>
9. AGE (In years last birthday) yrs. <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMICAL OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL COMPANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>HAMBLETON, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MC DANIEL</b>		14. MOTHER'S MAIDEN NAME <b>ISABEL CLICK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>236 14 62 32</b>	
17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS</b>		<b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS WITH METASTASES</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PULMONARY EMPHYSEMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>DEC. 9, 1966</b> , to <b>DEC 17, 1966</b> , that (I) (we) last saw the deceased alive on <b>DEC. 17, 1966</b> , and that death occurred at <b>1130PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>M. Adatepe</i>		22b. DATE SIGNED <b>12/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MUSTAFA H. ADATEPE, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/22/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>McCully Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

4831

5852

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16784

16785

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>REISTERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>419 SACRED HEART LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>NELLIE (ELLA A.) McGEE</b>		4. DATE OF DEATH <b>DECEMBER 1 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 23, 1878</b>
9. AGE (In years last birthday) <b>88</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>421-44-9733</b>	
17. INFORMANT <b>Mrs. Eugene Curtis, 419 Sacred Heart Lane,</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Angina Pectoris</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>12 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1963</b> , to <b>Dec. 1, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Nov. 28 1966</b> , and that death occurred at <b>9:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>D. D. Caples</b>		22b. DATE SIGNED <b>12-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>SECONDARY ANEMIA - HYPERTROPHIC ARTHRITIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 26, 1966</u> to <u>12/26, 1966</u> , that (I) (we) last saw the deceased alive on <u>DEC. 23, 1966</u> , and that death occurred at <u>2</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul R. Ziegler</u>		22b. DATE SIGNED <u>12/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL R. ZIEGLER</u>		22d. ADDRESS <u>200 CHESTNUT HILL DR EAK. CITY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-28-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt View Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Howard Co. Md</u>
24. FUNERAL DIRECTOR <u>Haight Funeral Home, Sykesville, Md</u>		25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Marriottsville</u> 13.2	
c. LENGTH OF STAY IN 1b <u>3 Months</u>		d. STREET ADDRESS <u>Sand Hill Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>200 Bloomsbury Ave</u> <u>Bloomsbury Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA MARY MC LEAN</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	9. AGE (In years last birthday) <u>90</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur McLean</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Hobbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-48-8426</u>	
17. INFORMANT <u>MR. Brown Cissel</u>		Address <u>- Marriottsville, Md.</u>	

16785

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16786

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16786

## CERTIFICATE OF DEATH

16787

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7827 Aiken Avenue</b>		d. STREET ADDRESS <b>7827 Aiken Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ETHEL HELEN McSORLEY</b>		4. DATE OF DEATH Month Day Year <b>December 17 19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1923</b>
9. AGE (In years lost birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>Harvey Herbert</b>		14. MOTHER'S MAIDEN NAME <b>Helen Crowe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218141663</b>	
17. INFORMANT <b>James Francis McSorley</b>		Address <b>--7827 Aiken Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of large bowel c</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>undiscovered metastases</b> lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>Dec</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec 17</b> , 19 <b>66</b> , and that death occurred at <b>12</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>12/19/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. S. Elliott Harris</b>		22d. ADDRESS <b>8100 Harford Rd. Balto. 34, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.---Baltimore, Md.--14</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16787 CERTIFICATE OF DEATH 16788											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>City</u> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> 30.4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Joseph Hospital</u>						d. STREET ADDRESS <u>3904 Hudson St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>J</u> Last <u>Merritt</u>			4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1966</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-29-47</u>		9. AGE (in years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Henry Merritt</u>						14. MOTHER'S MAIDEN NAME <u>Anna Flury</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>213-52-6678</u>		17. INFORMANT <u>Vernon Merritt</u>		Address <u>409 Celeste Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Grand Mal Seizure</u> 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Sub Acute Glomerulonephritis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 months</u> <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/21, 1966</u> , to <u>12/27, 1966</u> that (I) (we) last saw the deceased alive on <u>12/18, 1966</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William G. Esmond</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William G. Esmond MD</u>						22d. ADDRESS <u>537 STAMFORD ROAD, BALT. 25 MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>			23d. LOCATION (City, town or county) (State) <u>Md.</u>			
24. FUNERAL DIRECTOR <u>Helma A. Hoffmann</u>						ADDRESS <u>3218 Hudson St</u>		25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16788

CERTIFICATE OF DEATH

16789

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalls town</u>		c. LENGTH OF STAY IN 1b <u>132</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Mielke</u> Last <u>Mielke</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W-</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-96</u>
9. AGE (In years lost birthday) <u>70</u> -yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Brown</u>		14. MOTHER'S MAIDEN NAME <u>Susan Shipley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mr. Wm Mielke - Marriottsville, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Corporation Pneumonia</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>central Hemorrhage</u> DUE TO (c) <u>Hypertension essentially</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>5 days</u> <u>? years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>66</u> , to <u>12-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> , 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>L. D. Jager</u>		22b. DATE SIGNED <u>12-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. L. D. Jager</u>		22d. ADDRESS <u>Balto County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-19-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto County - Md.</u>
24. FUNERAL DIRECTOR <u>William H. Hartzel</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 23 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16789

CERTIFICATE OF DEATH

16790

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>30.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>4016 Dorchester Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>AMI</u> Last <u>Miliman</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/27/01</u>
9. AGE (In years lost birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Amusements</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hyman Miliman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-1236</u>	
17. INFORMANT <u>Mrs. Cecelia Miliman</u>		Address <u>4016 Dorchester Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cardiac Arrest probably new M.I.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO <u>Ischemic Heart Dis</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>16 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>66</u> , to <u>12-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> 19 <u>66</u> , and that death occurred at <u>11:54</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L. de Joya</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L. De Joya</u>		22d. ADDRESS <u>Balto. County Gen. Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Levenson Bros F.H.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



18789

ESTIMATE OF DEATH

18789

18789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16790

## CERTIFICATE OF DEATH

16791

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>141 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>20 S. KRESSON STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>MARION</b> Last <b>MILLER, SR</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/15/09</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>24</b> Hours <b>1966</b> Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLATE GRINDER</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL INDUSTRY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AUGUSTA COUNTY, GEORGIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SANDY MILLER</b>	
14. MOTHER'S MAIDEN NAME <b>MAGGIE MAE FISHER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWII</b>	
16. SOCIAL SECURITY NO. <b>228 09 74 38</b>		17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4/20.1</b> IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>(s)</del> (this hospital) attended the deceased from <b>8/5/66</b> , 19 to <b>12/24/66</b> , 19, that (i) (we) last saw the deceased alive on <b>12/24/66</b> , 19, and that death occurred at <b>8:03A</b> M, from causes on and on the date stated above.		22a. SIGNATURE <b>Jorge A. Fabara</b>	
22b. DATE SIGNED <b>12/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEN PARK NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>JOSEPH N. ZANNINO FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>1967</b>	
25a. ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>		25c. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>	

18731

18730

THE STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1873  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1872  
ALBANY: PUBLISHED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
1873

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16791

## CERTIFICATE OF DEATH

16792

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>03/1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>6608 Chippewa Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Millman, William</u>		4. DATE OF DEATH Month <u>12</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-04</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>11</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Israel Millman</u>		14. MOTHER'S MAIDEN NAME <u>Leah ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs Faye Millman, 6608 Chippewa Drive</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease</u> DUE TO (c) <u>Hypertensive heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>12-11-</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-11-</u> , 19 <u>66</u> to <u>12-11-</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12-11-</u> 19 <u>66</u> and that death occurred at <u>3:35</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Gracito V. Patricio</u>		22b. DATE SIGNED <u>12-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GRACITO V. PATRICIO</u>		22d. ADDRESS <u>BC &amp; C</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/12/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moses Montifiore</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sevenson Bros. 6010 Reisterstown Rd.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. DATE <u>DEC 15 1966</u>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1052

10521

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16792

16793

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>Baltimore</b>		<b>Baltimore - 21224</b> <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>Foster &amp; Conkling Sts.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rev. Henry E. MISSIG C.Ss.R.</b>		4. DATE OF DEATH Month Day Year <b>December 28 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-7-1901</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Priest</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY MISSIG</b>		14. MOTHER'S MAIDEN NAME <b>MARY STRIEGEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Rev. Carl Langhirt Balto., 21224, Md.</b>		Address <b>600 S. Conkling St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes - Gangrene of right foot.</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 9 th</b> , 19 <b>66</b> to <b>Dec. 28 th</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Dec. 28 th</b> , 19 <b>66</b> , and that death occurred at <b>1:35 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Mario Penafiel</b>		22b. DATE SIGNED <b>Dec. 28 th 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Mario Penafiel</b>		22d. ADDRESS <b>7620 York Road - Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-31-66.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>7401 German Hill Rd., Md.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Greder</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Greder</b>			



1833

1833





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16793

CERTIFICATE OF DEATH

16794

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>2502 Kitmore Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mittleman</b> Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1888</b>
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Russia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>unknown ISRAEL KLEINMAN</b>		14. MOTHER'S MAIDEN NAME <b>unknown HANCY FELDMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Not known</b>		16. SOCIAL SECURITY NO. <b>094-20-7346</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Heart Dis two yrs.</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b> 2 yrs.		INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Oct. 18</b> , 19 <b>66</b> to <b>Dec. 1</b> , 19 <b>66</b> that (X) (we) lost saw the deceased alive on <b>Dec. 1</b> , 19 <b>66</b> , and that death occurred at <b>9:10</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>12-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NATL. CAPITAL &amp; EBREW CEM. CAPITAL &amp; EBREW CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>Capitol Heights, MD.</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>4217-9-4</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 5 1966</b>	

18383

16301

RECEIVED BY STATE

RECEIVED BY STATE

NO.

RECEIVED BY STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16794

16795

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>167 Amherst St</u>	
3. NAME OF DECEASED (Type or print) <u>PAULINE MOHR</u>		4. DATE OF DEATH <u>Dec 31 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Meyer Katy</u>		14. MOTHER'S MAIDEN NAME <u>Bluma</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Leon Mohr</u>		Address <u>7006 Plymouth Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Cardio-Respiratory Failure</u> <u>170X</u> DUE TO <u>Consistent Heart Failure</u> (b) <u>Arteriosclerotic CVD</u> DUE TO <u>Carcinoma of Breast</u> (c) <u>Generalized Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>62</u> , to <u>Dec 31</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec 31</u> , 19 <u>66</u> , and that death occurred at <u>30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard Applefeld</u>		22b. DATE SIGNED <u>Jan 1/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLARD APPLEFELD</u>		22d. ADDRESS <u>Clark Hts &amp; Glen Ore</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Jan 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Not Lebanon</u>		23d. LOCATION (City, town or county) (State) <u>Long Island N.Y.</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Sons Inc</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>-6010 Reest. Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JAN 4 1967</u>			

10334

OFFICE OF THE SECRETARY OF THE ARMY

10334

10334



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16795

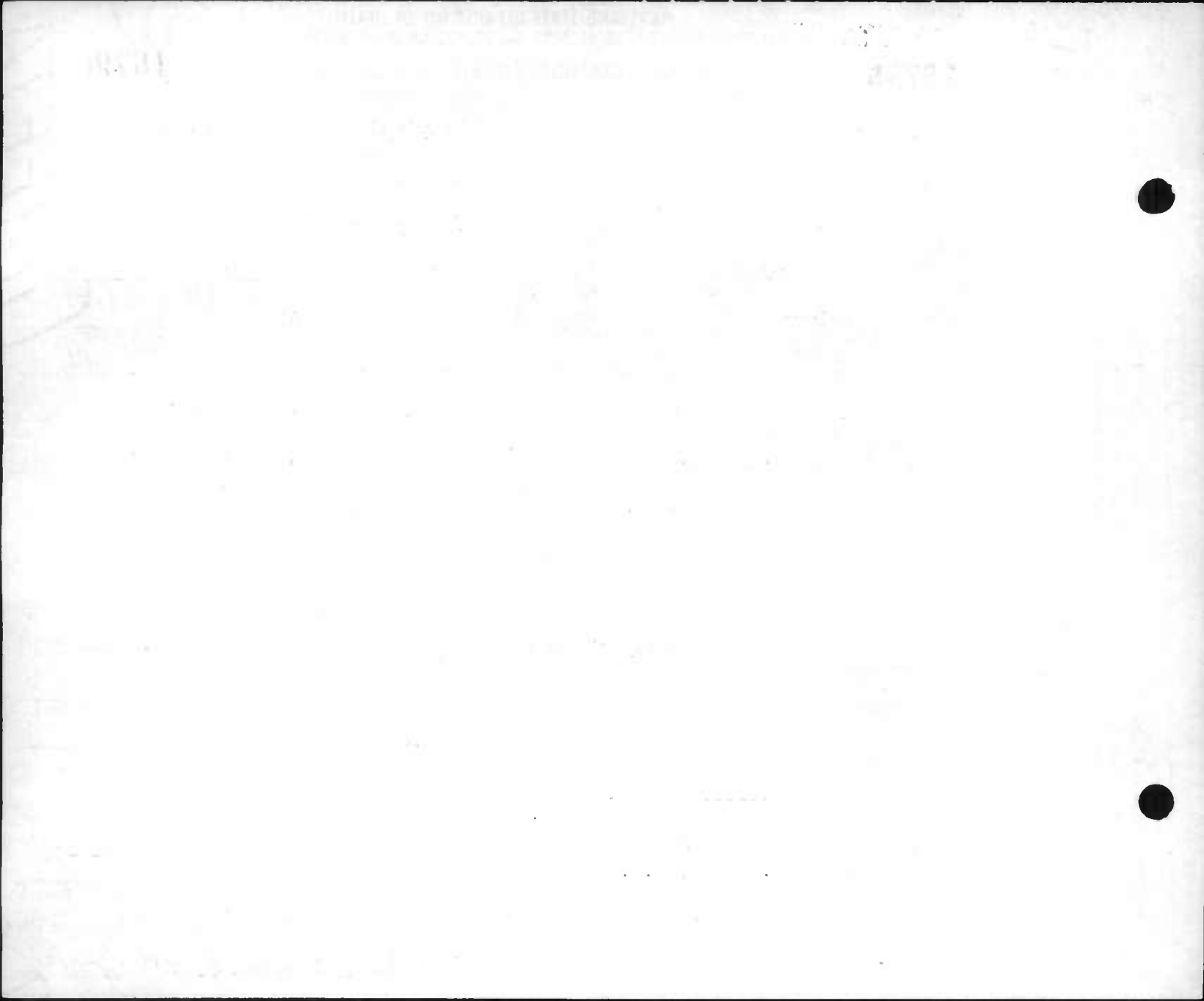
16796

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>28 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5 Mary Ave</b>				d. STREET ADDRESS <b>5 Mary Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES MOORE</b>				4. DATE OF DEATH Month Day Year <b>12 5 19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-23</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>12 5 19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Labour</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber yard</b>		11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Kelley Moore</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Penkey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.D. II 217-26-9311</b>		17. INFORMANT Address <b>Helen Smart 5 Mary Ave. Towson</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia and pulmonary abscess</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fatty alteration of liver</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D.				22. DATE SIGNED <b>11-6-66</b>			
EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. L. Chaturvedi 1701 M.E. Culver St</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16796

CERTIFICATE OF DEATH

16797

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>		d. STREET ADDRESS <b>Box 995</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GIBBONS</b> Middle <b>-</b> Last <b>MOORE SR.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 1, 1883</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>1</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial fruit grower</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Proprietor</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Rheese Moore</b>		14. MOTHER'S MAIDEN NAME <b>Ann Gambrill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-40-6411</b>	
17. INFORMANT <b>Gibbons Moore, Jr.,</b>		Address <b>Box 995, White Marsh, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Cardiac Failure with Pulmonary edema</b> DUE TO <b>(L.V. ventricular)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure with Atrial Fibrillation</b> DUE TO <b>3 yrs. 1 mos +</b> (c) <b>Arteriosclerotic Heart Disease - Coronary Thrombosis</b> <b>6 mos 8 yrs +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Massive Cardiac myopathy (H) Hospital Nov. 1965</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>Slip</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 6, 1966</b> to <b>Dec. 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov. 11, 1966</b> , and that death occurred at <b>8:30 P.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Isabel H. McClinton</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <b>Dec. 10, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Isabel H. McClinton, M.D.</b>		22d. ADDRESS <b>Kingsville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 13, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Camp Chapel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Perry Hall Balto Md</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md. 21009</b>		25a. REC'D BY REGISTRAR <b>DEC 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



10737

CERTIFICATE OF DEATH

10738

Name of Deceased		Date of Birth		Sex	
John Doe		1900-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York		1950-01-01		Heart Disease	
Occupation		Marital Status		Burial Place	
Teacher		Married		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
1950-01-01		New York		[Seal]	

Official Seal of the Registrar of Deaths, New York City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P. B. M. C.</u>		d. STREET ADDRESS <u>7839 Ellenham Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Clinton</u> First <u>Gerard</u> Middle <u>Morgan</u> Last		4. DATE OF DEATH <u>12.13.66</u> Month <u>12</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.31.97</u> 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invest. Banking Sartorius-Lipp Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clinton G. Morgan Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Emma Rane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716 07 1281</u>	
17. INFORMANT <u>C. Lapp</u> Address <u>P.B.M.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> DUE TO (b) <u>gastrojejunal ulcers</u> DUE TO (c) <u>Laennec's cirrhosis of liver &amp; A.S.H.D.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-24-66</u> , 19 <u>66</u> , to <u>12-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>66</u> , and that death occurred at <u>12:20</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>R. W. Smith</u>		22b. DATE SIGNED <u>12-13-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>Dec. 15, 1966</u>	<u>Green Mount</u>	<u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
<u>Stewart &amp; Mowen Co., 108 W. North Av., Balto.</u>		<u>Charles Judge</u>	
DATE		<u>DEC 14 1966</u>	

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R. W. Smith

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16798

## CERTIFICATE OF DEATH

16799

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN b <b>9 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospice</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4301 Roland Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Fuller</b> Last <b>Morgan</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3, 1881</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Holyoke, Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Kirk Fuller</b>				14. MOTHER'S MAIDEN NAME <b>Mary Garrett</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-03-2365</b>		17. INFORMANT Address <b>Hospice Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) <b>Aged</b> (e), stating the underlying cause last. DUE TO _____ Smoking (c) <b>Smoking</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (II) (this hospital) attended the deceased from <b>3-28-66</b> 19____, to <b>12-21-66</b> 19____, that (II) (we) last saw the deceased alive on <b>12-20-66</b> 19____, and that death occurred at <b>8:50A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert J. Mahon</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/22/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>				22d. ADDRESS <b>204 E. Joppa Road</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/23/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1873

STATE OF CALIFORNIA

1873

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16799

CERTIFICATE OF DEATH

16800

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>24 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>30.4</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1121 CARROLLTON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>STEPHEN ELLIS MORRIS</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 12 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 22, 1909</b> <b>57</b> yrs.	
9. AGE (In years lost birthday)		10. KIND OF BUSINESS OR INDUSTRY <b>ASSISTANT MANAGER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST POINT, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN MORRIS</b>				14. MOTHER'S MAIDEN NAME <b>COLUMBIA JONES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>218 14 53 01</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>BRONCHOPNEUMONIA DUE TO UNKNOWN ORGANISM</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>3 YEARS</b> <b>3 WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV 18</b> , 19 <b>66</b> , to <b>DEC 12</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 12</b> , 19 <b>66</b> , and that death occurred at <b>5:15 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Peter Juvan</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/12/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PETER JUWAN, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-15-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT</b> <b>1701 LAURENS ST. BALTIMORE, MD.</b>				25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16800

CERTIFICATE OF DEATH

16801

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3322 Willoughby Road</u>		d. STREET ADDRESS <u>3322 Willoughby Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>C.</u> Last <u>Mulgrew</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1901</u>
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Moylan</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>  </u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>Second degree burn of back</u>			INTERVAL BETWEEN ONSET AND DEATH <u>app 1 yr</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>10 Feb</u> , 19 <u>65</u> , to <u>11 Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10 Dec</u> , 19 <u>66</u> , and that death occurred at <u>6 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Howard Goodman</u>		22b. DATE SIGNED <u>12 Dec 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>		22d. ADDRESS <u>604 Harford Rd Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>Dec. 15, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16801

16802

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. LENGTH OF STAY IN 1b <u>5 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt Wilson State Hosp.</u>		d. STREET ADDRESS <u>1211 Shields Place</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES T. NEWKIRK</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucas.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-'14</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>242-32-5586</u>	
17. INFORMANT <u>Mt Wilson Hosp. Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002.1 Pulmonary Tbc.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. <u>None</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		22. DATE SIGNED <u>12-10-66</u>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/14/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>A A County Md</u>	
24. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>		25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

10802

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.


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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16802						16803					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> c. LENGTH OF STAY IN ID <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>122 Will O Brook Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Dorothy Mae NIXON</b>			4. DATE OF DEATH Month <b>12</b> Day <b>8</b> Year <b>19 66</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>4-7-54</b>			9. AGE (In years last birthday) <b>12 yrs.</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George Thomas Nixon</b>			14. MOTHER'S MAIDEN NAME <b>Clara Mae Johnston</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hemorrhagic lungs - tracheo bronchitis</b> DUE TO (b) <b>Aspiration of gastric contents</b> DUE TO (c) <b>Acute meningitis bronchopneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Institutionalized meningococci</b>		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			21. I certify that (this hospital) attended the deceased from <b>6-17</b> , 19 <b>60</b> , to <b>12-8</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>12-8</b> , 19 <b>66</b> , and that death occurred at <b>2:10 p.m.</b> on the causes and on the date stated above.		
22a. SIGNATURE <b>Consulting Pathologist Richard A. Jones</b>			22b. DATE SIGNED <b>12/9/66</b>			22c. PHYSICIAN'S NAME (Type) <b>Richard A. Jones, M.D.</b>			22d. ADDRESS <b>Carroll County Gen. Hosp.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>12/12/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>			23d. LOCATION (City, town or county) (State) <b>BALTO MD</b>		
24. FUNERAL DIRECTOR <b>Thomas J. Kenny Inc 1600 Collins St</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. DATE <b>DEC 13 1966</b>		

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 J. EDGAR HOOVER

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16803

## CERTIFICATE OF DEATH

16804

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>27yr6mth8d6s</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>407 E. Grindall Street</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>B.</b> Last <b>North</b>		4. DATE OF DEATH Month <b>December</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>maritime</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. North</b>		14. MOTHER'S MAIDEN NAME <b>Marcellene Osborne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-05-7666</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>10:15</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>6-14-39</b> to <b>Dec. 22, 1966</b> , that (1) <b>(x)</b> last saw the deceased alive on <b>Dec. 22, 1966</b> , and that death occurred at <b>10:15</b> M, from causes and on the date stated above.		
22a. SIGNATURE <b>Stella Wachslar</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-22-66</b>
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>	22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>
23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>		
24. FUNERAL DIRECTOR <b>JOHN F. DENNY, INC. 715 Light St.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16804

## CERTIFICATE OF DEATH

16805

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>14 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>431 E. Lorraine Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE B. OUTLAW</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 15 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/31/15</b>	
9. AGE (In years last birthday) yrs. <b>51</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>EDENTON, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JUDSON OUTLAW</b>				14. MOTHER'S MAIDEN NAME <b>MAMIE MILLER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>576 24 25 75</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema, post operative</b> 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aneurysm, cerebral</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>12/1/66</b> , 19__ to <b>12/15/66</b> , 19__, that <del>he</del> (we) last saw the deceased alive on <b>12/15/66</b> , 19__, and that death occurred at <b>8:45A</b> M, from causes on and on the date stated above.							
22a. SIGNATURE <i>Fuanguvudhiran Thavatchi</i> M.D.				22b. DATE SIGNED <b>12-16-66</b>		22c. PHYSICIAN'S NAME (Type) <b>FUANGVUDHIRAN, THAVATCHI, M. D.</b>	
22d. ADDRESS <b>FORT HOWARD VA. Hospital</b>				22e. REC'D BY REGISTRAR <b>Charles Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE THEREOF <b>Dec 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Northolt VA</b>	
24. FUNERAL DIRECTOR <b>Joseph N. Zannino Funeral Home</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

16806

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson XXXXXXXX</b>		c. LENGTH OF STAY IN 1b <b>6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XXXXXXXXXX Ruxton 03.1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa Nursing Home</b>			d. STREET ADDRESS <b>1903 Ruxton Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Bevan</b> Last <b>Park</b>			4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1966</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1886</b>	9. AGE (In years lost birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			13. FATHER'S NAME <b>Abram Bevan</b>		
14. MOTHER'S MAIDEN NAME <b>Cecile Blackwell</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>Dr. E. A. Park</b>			17. INFORMANT <b>(Same)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial infarction</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Presento</b>		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>19.5.5. to</b> , that (I) <del>first</del> last saw the deceased alive on <b>6 Dec 1966</b> , and that death occurred at <b>4 p.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Robert E. Mason</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6 Dec '66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert E. Mason</b>		22d. ADDRESS <b>9 E. Chase St - Balto 2 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>12/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>	
23d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>			25a. REC'D BY REGISTRAR DATE <b>DEC 7 1966</b>		
ADDRESS <b>4905 York Road Baltimore 12, Md.</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16806		Item 250 Film G-284 1/3/67 mb						16807			
1. PLACE OF DEATH a. COUNTY <b>BALTO. COUNTY.</b> <i>Jawson</i>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND.</b> b. COUNTY <b>MARYLAND.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. LENGTH OF STAY IN 1b <b>2 Mo. 7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 South Highland Ave. 30.4</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>						d. STREET ADDRESS <b>Baltimore, Md</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>John</b>		First		Middle <b>Albert</b>		Last <b>Patrick</b>		4. DATE OF DEATH <b>12</b>		Day <b>25</b> Year <b>1966</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/1/09</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CANNING CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PENNA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>STANLEY PATRICK</b>						14. MOTHER'S MAIDEN NAME <b>JOSEPHINE SCOVERN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-34-8927</b>		17. INFORMANT <b>E. STODZINSKI</b> Address <b>10 S. HIGHLAND AVE.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 18, 1966</b> to <b>Dec. 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 25, 1966</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert W. Smith</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-25-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Smith</b>						22d. ADDRESS <b>G-BMIC -</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>12/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>			23d. LOCATION (City, town or county) (State) <b>BALTO. CO. MD.</b>			
24. FUNERAL DIRECTOR <b>W. FIALKOWSKI</b>						ADDRESS <b>2007 EASTERN AVE.</b>		25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
<b>W. Fialkowski</b>						<b>BALTO. MD. 21231</b>					

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Robert W. Smith

Greater Baltimore Medical Center, Baltimore, MD

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Robert W. Smith

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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16808

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>2443 MC CULLOH STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH (NMI) PEEL</b> 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>8/26/96</b> 9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			4. DATE OF DEATH Month Day Year <b>DECEMBER 24 1966</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MESSANGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE MEDICAL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>RICH SQUARE, N. CAROLINA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>MACK PEEL</b>				
14. MOTHER'S MAIDEN NAME <b>TIMPIE SCOTT</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>				
16. SOCIAL SECURITY NO. <b>231 26 39 13</b>		17. INFORMANT Address <b>CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from <b>December 23, 1966</b> , to <b>December 24, 1966</b> that (1) (we) last saw the deceased alive on <b>Dec. 24, 1966</b> , and that death occurred at <b>9:35 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Sheldon E. Kalmutz</b> M.D.			22b. DATE SIGNED <b>12/26/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M.D.</b>			22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MD.</b>				
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-29-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>			
23d. LOCATION (City or Town) (County) (State) <b>Norfolk, Virginia</b>		24. FUNERAL DIRECTOR <b>George Kelson Funeral Home</b>					
25a. REC'D BY REGISTRAR <b>DATE 12 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16808

CERTIFICATE OF DEATH

16809

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Convalescent Home</u>				d. STREET ADDRESS <u>7020 Alden Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Marie</u> Last <u>Reel</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1877</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Schmidt</u>				14. MOTHER'S MAIDEN NAME <u>Anna Klingelhofer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-48-079</u>		17. INFORMANT Address <u>Pikesville 8, Md.</u> <u>Mrs. Carolyn Yvonne Eaton, 7020 Alden Rd.,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>chronic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>obese</u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1930</u> to <u>12-25-1966</u> , that (I) (we) last saw the deceased alive on <u>12-24-1966</u> , and that death occurred at <u>12:25</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James G. Saffell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>				22d. ADDRESS <u>Reisterstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 28, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>				ADDRESS <u>Pikesville 8, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 28 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10203

CERTIFICATE OF AFRICA

10203

10203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16809

CERTIFICATE OF DEATH

16810

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>1 yr. 6 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Home of Md.</u>		d. STREET ADDRESS <u>202 CHURCH LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louis</u> First Middle Last <u>Pepler</u>		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1877</u>
9. AGE (In years last birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u> Hours <u>19</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Est. &amp; Ins.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Pepler</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Rolser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-2502-A</u>	
17. INFORMANT <u>Masonic Home Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. BRONCHO PNEUMONIA</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2. CEREBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> to <u>Dec 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 17</u> , 19 <u>66</u> , and that death occurred at <u>11:19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>JAMSHID HAMED MD</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>		22b. DATE SIGNED <u>12/18/66</u>	
22d. ADDRESS <u>Cockeysville, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/20/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 23 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11891

98321



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

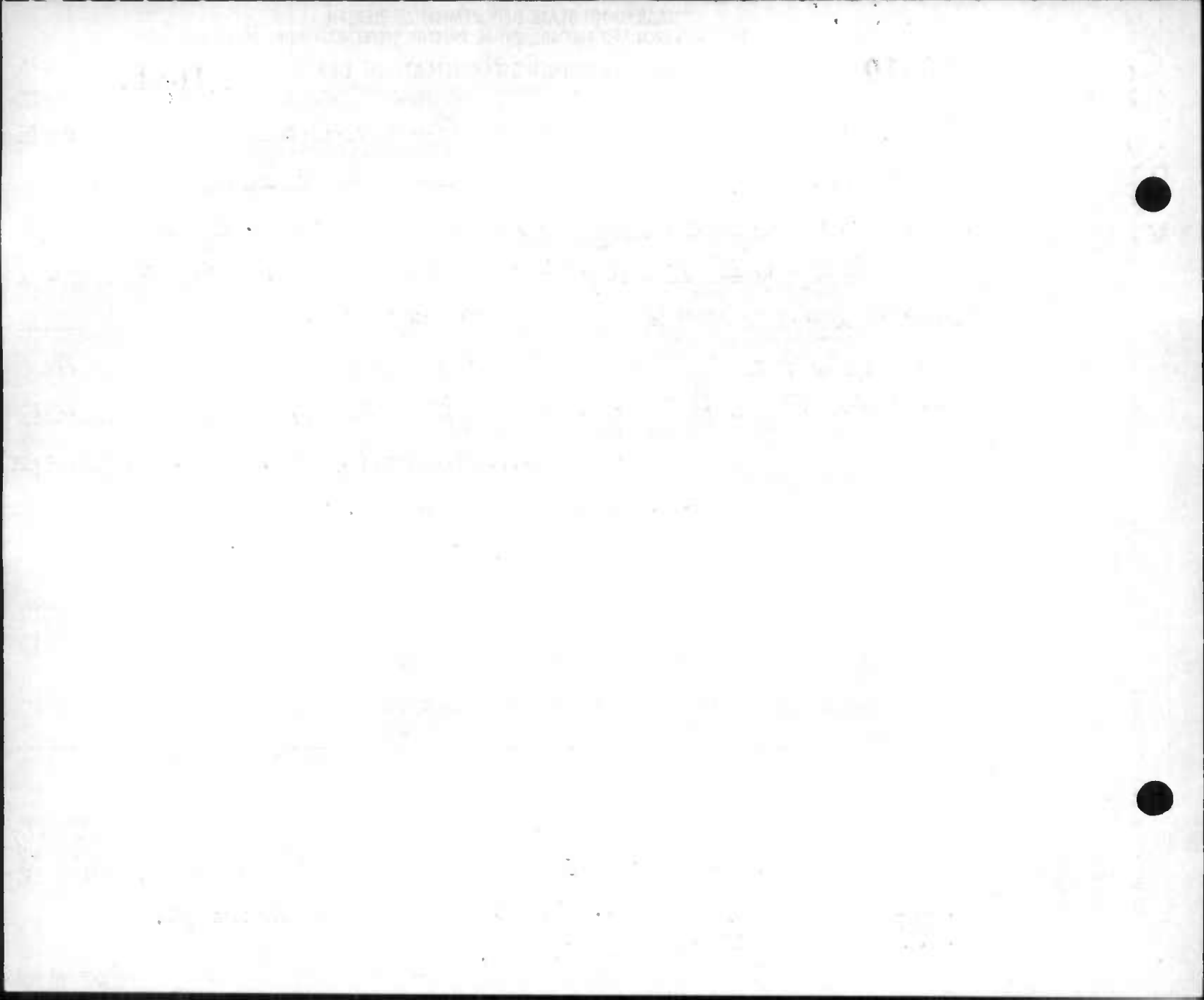
16810

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16811

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1553 CLARIDGE RD 21207</u>				d. STREET ADDRESS <u>1553 CLARIDGE RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERYL EMILY PESCHAU</u>				4. DATE OF DEATH Month Day Year <u>DEC 31 19 66</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 14, 1894</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN F SPENCER</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA B. CRUSE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. -		17. INFORMANT <u>MISS BERYL PESCHAU</u> Address <u>SAME ADDRESS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COMPLETE HEART BLOCK</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>5 YR.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John N. Snyder</u>		EXAMINER'S NAME (Type) <u>JOHN N. SNYDER</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>6348 FREDERICK RD</u>		22. DATE SIGNED <u>JAN 2, 1967</u> <u>21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>J. F. Stansbury</u>				ADDRESS <u>6411 Windsor Mill Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16811

## CERTIFICATE OF DEATH

16812

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>BALTIMORE</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b> 031		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WINANS ROAD</b>				d. STREET ADDRESS <b>WINANS ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RAYMOND J. PFEIFFER</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 15 1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-22-1894</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO MECHANIC</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>216-01-3718</b>		17. INFORMANT Address <b>Dora L. Pfeiffer - Winans Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abnormal heart function - Congestive failure</b> DUE TO (b) <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>OCT 12, 1966</b> to <b>DEC 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/12/66</b> , and that death occurred at <b>1:45 P.M.</b> from causes and on the date stated above. 22a. SIGNATURE <b>Edwin L. Pierpont</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12/16/66</b> 22c. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, MD</b> 22d. ADDRESS <b>8204 LIBERTY RD - BALTO, 21207, MD</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12-19-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b> 24. FUNERAL DIRECTOR <b>Edmund Purcell</b> ADDRESS <b>4600 Liberty Hgts, Ave.</b> 25a. REC'D BY REGISTRAR <b>DEC 19 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1881

STATE OF OHIO

1881

RECEIVED  
JAN 10 1881  
DEPT. OF AGRICULTURE  
WASHINGTON  
D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>16812</b> PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shady Nook Nursing Home</b>					<b>16813</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daniels</b> d. STREET ADDRESS <b>13.2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>ETHEL GERTRUDE PILCHER</b> First Middle Last 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>April 1, 1895</b> 9. AGE (In years last birthday) <b>71</b> yrs. 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mln.					4. DATE OF DEATH <b>December 25, 1966</b> 19 11. BIRTHPLACE (County & State, or foreign country) <b>Alberton, Md</b> 12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Not Known</b> 14. MOTHER'S MAIDEN NAME <b>Not Known</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>?</b> 17. INFORMANT Address <b>Mrs. Beatrice Waltz, Daniels, Md</b>					18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> (c) <b>or</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ocular lesions - paraplegia following surgery</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1966</b> to <b>Dec 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/20 / 1966</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Cliff Ratliff, Jr.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b> 22d. ADDRESS <b>4605 Edmonson ave</b> 22b. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12-28-1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b> 23d. LOCATION (City, town or county) (State) <b>Ellicott City, Md</b>					24. FUNERAL DIRECTOR <b>F.C. Higinbotham</b> ADDRESS <b>Ellicott City, Md</b> 25a. REC'D BY REGISTRAR <b>DEC 28 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Maryland Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge</u>				c. LENGTH OF STAY IN 1b <u>03.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>231 Register Avenue</u>				d. STREET ADDRESS <u>231 Register Avenue 21212</u>			
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>M.</u> Last <u>Pirie</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1909</u>	
9. AGE (in years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Receptionist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W.F.B.R. - Radio</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>  </u>							
13. FATHER'S NAME <u>Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Edith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>084-14-1096</u>			
17. INFORMANT <u>Mr. William S. Pirie, Jr. same address as above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19 59</u> to <u>Dec. 19 66</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>October 19 66</u> , and that death occurred at <u>9:30 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles E. Carr, Jr.</u> M.D.				22b. DATE SIGNED <u>12/30/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles E. Carr, Jr., M.D.</u>				22d. ADDRESS <u>3900 N. Charles Street 21218</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/31/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Fickner &amp; Sons</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>  </u>				DATE <u>Jan 3 1967</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16815

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiltondale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>		d. STREET ADDRESS <u>511 Yarmouth Road 21204</u>	
3. NAME OF DECEASED (Type or print) <u>Mary HELEN B PODLICH</u>		4. DATE OF DEATH <u>Dec. 9 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-1917</u>
9. AGE (In years last birthday) <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joe P. Burnett</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-40-3977</u>	
17. INFORMANT <u>Harry Podlich</u>		Address <u>116 W. University</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Grav. neg. Septicemia.</u> DUE TO (b) <u>Chronic urinary tract infection</u> DUE TO (c) <u>Fracture L. Hip</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell going to dining room at nursing home</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-22 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>		20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/12/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City or Town) <u>Baltimore, Md.</u> (County) (State)	
24. FUNERAL DIRECTOR <u>Wm J. Tucker &amp; Son</u>		ADDRESS <u>214 La Aves</u>	
25a. REC'D BY REGISTRAR <u>DEC 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16815

CERTIFICATE OF DEATH

16816

1. PLACE OF DEATH a. COUNTY <b>Baltimore, County, Lutherville, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>7</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>College Manor Nursing Home</b>		d. STREET ADDRESS <b>3430 Edmondson Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Florence Kiel Poffenberger</b>		4. DATE OF DEATH Month <b>12-9-</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 28, 1889</b>
9a. AGE (In years last birthday) <b>77</b> yrs.		9b. IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Kiel</b>		14. MOTHER'S MAIDEN NAME <b>Kate</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Evelyn P. Poffenberger</b> <b>3430 Edmondson Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>199.2</b> IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12, 1962</b> to <b>present</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 8, 1966</b> and that death occurred at <b>12:30</b> PM, from causes and on the date stated above.			
22a. SIGNATURE <b>Ernest C. Brown Jr.</b>		22b. DATE SIGNED <b>12/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest C. Brown, Jr.</b>		22d. ADDRESS <b>550 N. Broadway</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Sharpsburg, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F.D. - 4101 Edmondson Ave. - Balto., Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16816 CERTIFICATE OF DEATH 16817

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN lb <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4420 Old Frederick Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Warner</u> First <u>M.</u> Middle <u>Pollak</u> Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>Cau</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/5/47</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			4. DATE OF DEATH <u>December 17 1966</u> Month Day Year		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Columbus, Ohio</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Marvin Pollak</u> 14. MOTHER'S MAIDEN NAME <u>Luise Warner</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>215-32-4272</u> 17. INFORMANT <u>Mrs. Grace Pollak</u> Address <u>4420 Old Frederick Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>163X</u> DUE TO (b) <u>CARCINOMA OF LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ARTERIO SCLEROSIS</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> , 19 <u>66</u> , to <u>Dec 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 17 1966</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Kuwilsky</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>12-17-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dora C. Kuwilsky</u> 22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-21-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Witzke F.D.-4101 Edmondson Ave.</u>			25a. REC'D BY REGISTRAR <u>DEC 19 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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THE OFFICE OF THE  
ATTORNEY GENERAL

Dec 13 1966

December 13 1966

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General Sullivan  
Herald Center

John C. Sullivan  
Herald Center



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16817

## CERTIFICATE OF DEATH

16818

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1827 Thornton Ridge Rd.</b>				d. STREET ADDRESS <b>1827 Thornton Ridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Karl</b> Middle <b>E.</b> Last <b>Portz</b>				4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1924</b>		9. AGE (In years lost birthday) <b>42 yrs.</b>	IF UNDER 1 YEAR Months <b>42</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Eng.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bendix</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chicago Heights Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry G. Portz</b>				14. MOTHER'S MAIDEN NAME <b>Olaug B. Pedersen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Korean War</b>		16. SOCIAL SECURITY NO. <b>318-20-0113</b>		17. INFORMANT Address <b>Mrs. Elizabeth G. Portz 1827 Thornton Ridge</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Sudden death</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Rd</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-21-66</b> , 19 <b>66</b> , to <b>4-7</b> , 19 <b>66</b> that (I) (we) lost the deceased alive on <b>4-7</b> , 19 <b>66</b> , and that death occurred at <b>6:00 A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>DONALD O. WOOD, M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>YORK ROAD AND GREENMEADOW DRIVE</b>				22d. ADDRESS			
TIMONUM, MARYLAND 21203							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>				25. REC'D BY REGISTRAR <b>568 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by Medical Examiner Dr. Charles F. O'Donnell



1881

REPUBLIC OF CHINA

1881

Article 10

Article 11

1881

1881

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16818

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. LENGTH OF STAY IN 1b <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenarm Road, Glenarm, Md.</b>		d. STREET ADDRESS <b>Glenarm Road, Glenarm, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Carolita</b> Middle <b>Pribil</b> Last <b>Pribil</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>February 25, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>	9. AGE (In years lost birthday) <b>80 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Martin Pribil</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Samec</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-54-9743-J1</b>	
17. INFORMANT <b>Sister M. Kathleen</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary occlusion</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 19</b> , 19 <b>66</b> , to <b>Dec 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct 26</b> , 19 <b>66</b> , and that death occurred at <b>6:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry L. McCorkle</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>12-28-66</b>
22c. PHYSICIAN'S NAME (Type) <b>HENRY L. MCCORKLE MD</b>		22d. ADDRESS <b>Phoenix Maryland 21131</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Dec. 29, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sisters Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Arm, Maryland</b>
24. FUNERAL DIRECTOR <b>Raymond J. Curran, 817 Scarlett Dr., Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR <b>JAN 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>										
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN lb <b>40 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6905 Railway Ave</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTO. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6905 Railway Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Stanislaus B. Przyborowski</b>			<b>4. DATE OF DEATH</b> <b>12 27 1966</b>			<b>5. SEX</b> <b>M</b> <b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>May 18-1896</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>tailor</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lebow Bros</b>			<b>9. AGE</b> (In years last birthday) <b>70 yrs.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Poland</b>		
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>			<b>13. FATHER'S NAME</b> <b>Konstanty Przyborowski</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Placyda Chluczinski</b>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>213-10-6432A</b>			<b>17. INFORMANT</b> <b>Stanley Przyborowski</b>			<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial And Arterio Sclerosis</b> (b) <b>Cardio-vascular Disease</b> (c) <b>443X</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b>			<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
<b>ACTUAL SIGNATURE</b> <b>M.B. Davis</b>			<b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>22. DATE SIGNED</b> <b>12/28/66</b>	
<b>EXAMINER'S NAME (Type)</b> <b>M.B. Davis MD-6800 Medical</b>			<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>							
<b>23b. DATE THEREOF</b> <b>12-31-1966</b>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Rosary</b>			<b>23d. LOCATION (City, town or county)</b> <b>Baltimore, Md.</b>			<b>(State)</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Walter Dabrowski 1005 Dundalk Ave.</b>			<b>25a. REC'D BY REGISTRAR</b> <b>DEC 29 1966</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			<b>DATE</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16820

## CERTIFICATE OF DEATH

16821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>88 MELLOR AVE</b>		d. STREET ADDRESS <b>88 MELLOR AVE</b>	
3. NAME OF DECEASED (Type or print) <b>MARY J. QUILLIAN</b> First Middle Last		4. DATE OF DEATH <b>DEC 27 1966</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 7, 1879</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN W. KAISERSKI</b>		14. MOTHER'S MAIDEN NAME <b>JULIA WEIVER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HARRY QUILLIAN</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> , 19, to <b>Dec 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>1227</b> 1966, and that death occurred at <b>3</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>DANIAN P. Alagia</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DANIAN P. Alagia</b>		22d. ADDRESS <b>3316 Frederick Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>BURIAL</b>	<b>12/30/66</b>	<b>CATHEDRAL</b>	<b>BALTO MD.</b>
24. FUNERAL DIRECTOR <b>E. S. MALNABR</b> ADDRESS <b>301 FREDERICK RD 21228</b>		25a. REC'D BY REGISTRAR <b>JAN 3 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

16880

CERTIFICATE OF DEATH

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Blank certificate form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

16822

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jowson</u>		c. LENGTH OF STAY IN 1b <u>30.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women + Aged Men's Home</u>		d. STREET ADDRESS <u>1621 Elkins Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary A Rae</u>		4. DATE OF DEATH Month Day Year <u>December 14 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 4, 1873</u> 93 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Denny</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-1727</u>	
17. INFORMANT Address <u>Mrs. Adele Wallace 5801 Lochlea Rd. #9</u>			
1b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Brain Syndrome</u> DUE TO (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>2 years</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12</u> , 19 <u>52</u> , to <u>Dec. 14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 14</u> , 19 <u>66</u> , and that death occurred at <u>5:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>December 14, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day</u>		22d. ADDRESS <u>4-E-33rd St Balto 21218 Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR <u>DEC 20 1966</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

#S831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16822					16823						
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard Co.</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			d. STREET ADDRESS <b>414 Bonnie Branch Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Henry Joseph Raphael</b>			First Middle Last		4. DATE OF DEATH <b>Dec. 18 1966</b>		Month Day Year				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-7-13</b>		9. AGE (In years last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLANNING &amp; ZONING CONSULTANT</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Henry J. Raphael</b>					14. MOTHER'S MAIDEN NAME <b>Corinne Flery</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-07-8938</b>		17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pulmonary Fibrosis and</b> (c) <b>Emphysema</b>										INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 2, 1966</b> to <b>Dec. 18, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 18 19 66</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. Newcomer</b>								22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>								22d. ADDRESS <b>Mount Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>				23d. LOCATION (City, town or county) (State) <b>Ellicott City, Md</b>			
24. FUNERAL DIRECTOR <b>F.C. Higinbotham</b>						25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

16823

16823

Bellevue County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Mr. Raymond, N. J. Superintendent, Mount Wilson, Maryland

Wilson, N. J.

St. Johns

Mr. Raymond, N. J. Superintendent, Mount Wilson, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16823

CERTIFICATE OF DEATH

16824

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>30.4</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1322 E. Belvedere Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marian Ethel REESE</b>				4. DATE OF DEATH Month Day Year <b>December 14, 1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1987</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Garrett</b>				14. MOTHER'S MAIDEN NAME <b>Sarah L. Knight</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>RR</b>		17. INFORMANT <b>G. Herbert Reese</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary infarction</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>A</b> (this hospital) attended the deceased from <b>12/10/</b> , 19 <b>66</b> , to <b>12/14/</b> , 19 <b>66</b> , that <b>A</b> (we) last saw the deceased alive on <b>12/14/</b> , 19 <b>66</b> , and that death occurred at <b>7:30 M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>				22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/16/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>I.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1883

1883

THE STATE OF OHIO

WILLIAM A. HARRISON

May 10, 1883

My dear Mr. Harrison

I have the honor to acknowledge the receipt of your letter of the 10th inst.



Yours very truly

W. A. HARRISON

W. A. HARRISON, Secy. of State



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16824 CERTIFICATE OF DEATH 16825

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>8 yrs</u> <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>			d. STREET ADDRESS <u>9523 Belair Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Eugene H. Reider</u>	First	Middle	Last	4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/14</u> <u>52 yrs.</u>	9. AGE (In years last birthday) <u>52 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>York County - Penn</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID Reider</u>			14. MOTHER'S MAIDEN NAME <u>N.A. Sarah Howard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>213-07-6392</u>		17. INFORMANT <u>PATIENTS CHART</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest with attempt of resuscitation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Acute Myocardial infarction</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 16</u> , 19 <u>66</u> , to <u>Dec. 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 2</u> , 19 <u>66</u> , and that death occurred at <u>1<sup>st</sup></u> PM, from the causes and on the date stated above.					
22a. SIGNATURE <u>Doro C. Kuwilsky</u>			22b. DATE SIGNED <u>12-2-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Doro C. Kuwilsky</u>			22d. ADDRESS <u>Greater Baltimore Medical Center</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	
23d. LOCATION (City, town or county)		(State) <u>Penna.</u>			
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			DATE <u>DEC 3 1966</u>		



1885

1885

RECORD OF DEATHS

*[Faint, mostly illegible text from a record book, likely containing names, dates, and locations. The text is mirrored across the page.]*

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16825

CERTIFICATE OF DEATH

16826

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>24 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAKE SHORE, PASADENA</b>	
f. STREET ADDRESS <b>ROUTE 10, BOX 92</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>WILLIAM</b> Last <b>REMBOLD</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>16</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 6, 1896</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICE OFFICER (ret.)</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City P.D.</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D.C.</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>GEORGE REMBOLD</b>		15. MOTHER'S MAIDEN NAME <b>BERNADINE MAY</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		17. SOCIAL SECURITY NO. <b>216 28 01 19</b>	
18. INFORMANT <b>VA HOSPITAL</b>		19. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CARCINOMA OF PROSTATE WITH METASTASIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 22</b> , 19 <b>66</b> , to <b>DEC 16</b> , 19 <b>66</b> , that (I) (we) lost saw the deceased alive on <b>DEC 16</b> , 19 <b>66</b> , and that death occurred at <b>1005AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Peter V. Juvan</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Dec. 20/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVETT CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>
24. FUNERAL DIRECTOR <b>SINGLETON FUNERAL HOME, CRA IN HIGHWAY, GLEN BURNIE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

2532

35881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16826

CERTIFICATE OF DEATH

18050

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>1/2 HOUR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>8205 SHORE ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>J.</b> Last <b>REMLEIN</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>DECEMBER 20, 1894</b> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>James J. Lacy Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN REMLEIN</b>		14. MOTHER'S MAIDEN NAME <b>FREIDA RICHER YOUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213 10 32 05</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA LEFT LUNG</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PULMONARY EMPHYSEMA</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BENIGN PROSTATIC HYPERTROPHY</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>12/20/66</b> , 19__ to <b>12/20/66</b> , 19__, that <del>we</del> (we) last saw the deceased alive on <b>12/20/66</b> , 19__, and that death occurred at <b>12:30PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED <b>12/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-23-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>John J. Duda,</b>		25a. REC'D BY REGISTRAR <b>JOHN J. DUDA FUNERAL HOME</b> DATE <b>JAN 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>John J. Duda</i>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16827

16827

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2700 Taylor Ave.</u>		d. STREET ADDRESS <u>2700 Taylor Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ignatz</u> Middle <u>Rickert</u> Last <u>Dec.</u>		4. DATE OF DEATH Month <u>13</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>03</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store-Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212322154</u>	
17. INFORMANT <u>Karl Rademacher</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular-Renal disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia, right</u> DUE TO (c) <u>1950</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1943</u> to <u>Dec. 13 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10 1966</u> and that death occurred at <u>11:28 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. M. Bacon</u>		22b. DATE SIGNED <u>12/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. M. BACON</u>		22d. ADDRESS <u>2810 Taylor Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>12/15/66.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. RECEIVED BY REGISTRAR <u>DEC 20 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18831

RECEIVED BY DEPT. OF AGRICULTURE

18831

RECEIVED BY DEPT. OF AGRICULTURE  
OFFICE OF THE SECRETARY  
WASHINGTON, D. C.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16828

16828

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 825 Dorsey Avenue</b>				d. STREET ADDRESS <b>525 Dorsey Road, 21221</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>E.</b> Last <b>Ricketts, Sr.</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>23</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 4-1888</b>		9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reading Construction Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-2610-A</b>		17. INFORMANT <b>760 Fulbrook Rd., Son, James Ricketts, Dundalk, Maryland 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>422.1 H-S-C-V-Disease</b> IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type)		22. DATE SIGNED <b>12-26-1966</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-26-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland 21213</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>				25. RECEIVED BY (REGISTER) <b>DEC 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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CERTIFICATE OF DEATH

16829

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1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>60 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1717 LIGHT STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEO ROBERTSON</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 13 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 30, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reg. Corps</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID F. ROBERTSON</b>		14. MOTHER'S MAIDEN NAME <b>ZEPP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>216 07 90 64</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL, ASPIRATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>UREMIA</b> DUE TO (c) <b>CHRONIC PYELONEPHRITIS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME DUE TO CEREBRAL ARTERIOSCLEROSIS, ACUTE RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS, ARTERIOSCLEROTIC HEART DISEASE, HYPERTENSIVE CARDIOVASCULAR DISEASE, DIABETES MELLITUS</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>11</b> (this hospital) attended the deceased from <b>OCT. 14</b> , 19 <b>66</b> , to <b>DEC. 13</b> , 19 <b>66</b> , that <b>11</b> (we) last saw the deceased alive on <b>DEC. 13</b> 19 <b>66</b> , and that death occurred at <b>11:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>NEILON NEILON, M.D.</b>		22b. DATE SIGNED <b>12/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILON, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/19/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>RITCHIE HIGHWAY, BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>MC COLLY FUNERAL</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 15 1966</b>	
HOME, East Fort Ave., Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16830

## CERTIFICATE OF DEATH

16830

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>121 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>651 W. LEXINGTON STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>LEE</b> Last <b>ROBEY</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>5/28/11</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEAT CUTTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUTCHER SHOP</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GLADYS, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT L. ROBEY, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>NANNIE K. DALTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>214 09 79 45</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>CARCINOMA OF LEFT PAROTID GLAND WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>it</b> (this hospital) attended the deceased from <b>8/15/66</b> , 19____, to <b>12/14/66</b> , 19____, that <b>it</b> (we) last saw the deceased alive on <b>12/14/66</b> , 19____, and that death occurred at <b>5:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>12/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-19-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>RUCK FUNERAL HOME</b> <b>HARTFORD ROAD, BALTIMORE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 20 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

U.S. DEPARTMENT OF AGRICULTURE

FILE NO. 100-1172, 100-10044

FILE NO. 100-1172, 100-10044

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U.S. DEPARTMENT OF AGRICULTURE

FILE NO. 100-1172, 100-10044

FILE NO. 100-1172, 100-10044

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FILE NO. 100-1172, 100-10044

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16831

## CERTIFICATE OF DEATH

16831

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenspring Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> d. STREET ADDRESS <u>Greenspring Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nannie E. Robinson</u>		<b>4. DATE OF DEATH</b> <u>Dec. 4, 1966</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 28, 1899</u>		<b>9. AGE (in years last birthday)</b> <u>67</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Balto. Co. Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Edward Keyes</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Fowler</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>218-32-7248</u>				<b>17. INFORMANT</b> <u>Mr. Alvin E. Robinson</u>				<b>Address</b> <u>Lutherville, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - acute</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> (a), stating the underlying cause last. (c) <u>Congestive Heart Failure -</u> <u>Arteriosclerosis - Chronic</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> <u>Span</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>  </u> <u>  </u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town) (County) (State)</b> <u>  </u> <u>  </u> <u>  </u>							
<b>21. I certify that (I) (this hospital) attended the deceased from November 3, 1966 to December 4, 1966, that (I) (we) last saw the deceased alive on December 3, 1966, and that death occurred at 3:30 PM, from the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>Charles E. McWilliams</u> M.D.								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>December 4, 1966</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Charles E. McWilliams</u>								<b>22d. ADDRESS</b> <u>Reisterstown Maryland</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/7/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Carrolls Chapel</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>Lutherville, Md.</u>							
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. F. Eline &amp; Sons</u>								<b>ADDRESS</b> <u>Reisterstown, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE DEC 7 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16832

18051

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-la Nursing Home, 333 Harlem Lane</b>			d. STREET ADDRESS <b>4430 Buchanan Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First BESSIE Middle E. Last RODGERS</b>			4. DATE OF DEATH <b>Month DEC. Day 19 Year 1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>24 Dec 1877</b>	9. AGE (In years last birthday) <b>88</b> yrs. IF UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William D. Caltrider</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>John F. Rodgers III, 1003 Kent Ave., 21228</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> <b>422.1</b> DUE TO <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 YR +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan, 1966</b> , to <b>12/19, 1966</b> , that (I) (we) last saw the deceased alive on <b>12/18, 1966</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Thomas E. Roach</b>			22b. DATE SIGNED <b>12/20/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas E. Roach</b>			22d. ADDRESS <b>5550 Balto. National Pike</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>21 Dec 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Carroll Co. Maryland</b>
24. FUNERAL DIRECTOR <b>Burgee Funeral Home, Baltimore, Maryland</b>			25a. REC'D BY REGISTRAR <b>DEC 23 1966</b>		
By: <b>Anna Burgee Jr</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
BUREAU OF STATISTICAL RESEARCH AND RECORDS  
CERTIFICATE OF DEATH  
1885

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John A. Smith		Male		35		1885		10:00 AM		Boston		Heart Disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Residence		14. Occupation		15. Education		16. Religion		17. Marital status		18. Date of birth		19. Date of death		20. Date of burial	
Mary A. Smith		Wife		Boston		Teacher		High School		Roman Catholic		Married		1850		1885		1885	
21. Name of funeral home		22. Name of cemetery		23. Name of church		24. Name of minister		25. Name of sexton		26. Name of undertaker		27. Name of embalmer		28. Name of casket		29. Name of coffin		30. Name of shroud	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

Check only one of either cause of death or manner of death. Check all that apply. See also definitions on page 10.

1. Heart Disease: A disease of the heart muscle, which may be caused by various factors, such as high blood pressure, atherosclerosis, or coronary artery disease. It may result in a heart attack or heart failure.

2. Natural: Death resulting from natural causes, such as old age or disease.

3. Accidental: Death resulting from an accident, such as a fall, fire, or drowning.

4. Suicide: Death resulting from self-harm.

5. Homicide: Death resulting from the action of another person.

6. Undetermined: Death where the cause is not known or cannot be determined.

7. Stillborn: A child born dead.

8. Abortion: The termination of a pregnancy.

9. Miscarriage: The spontaneous loss of a fetus.

10. Infant mortality: Death of an infant under the age of one.

11. Maternal mortality: Death of a woman during or shortly after childbirth.

12. Sudden death: Death occurring unexpectedly and without obvious cause.

13. Chronic disease: A long-lasting condition that can't be cured but can be managed.

14. Acute disease: A short-term illness that usually has a rapid onset and a quick recovery.

15. Infectious disease: A disease caused by a microorganism, such as a virus or bacterium.

16. Non-infectious disease: A disease that is not caused by a microorganism.

17. Trauma: Physical injury caused by an external force.

18. Poisoning: Death caused by the ingestion, inhalation, or absorption of a toxic substance.

19. Overdose: Death caused by taking too much of a drug or medication.

20. Anesthesia: Death caused by the use of anesthesia during surgery.

21. Execution: Death by legal means.

22. War: Death caused by armed conflict.

23. Riot: Death caused by a violent disturbance.

24. Terrorism: Death caused by acts of terror.

25. Suicide bombing: Death caused by a person blowing themselves up.

26. Gunshot: Death caused by a bullet.

27. Knife wound: Death caused by a sharp object.

28. Fire: Death caused by flames.

29. Drowning: Death caused by being underwater.

30. Fall: Death caused by falling from a height.

31. Car accident: Death caused by a motor vehicle collision.

32. Plane crash: Death caused by an aircraft accident.

33. Shipwreck: Death caused by a boat sinking.

34. Lightning: Death caused by a lightning strike.

35. Frostbite: Death caused by extreme cold.

36. Heatstroke: Death caused by extreme heat.

37. Suffocation: Death caused by lack of oxygen.

38. Asphyxiation: Death caused by the inability to breathe.

39. Starvation: Death caused by lack of food.

40. Dehydration: Death caused by lack of water.

41. Overexertion: Death caused by extreme physical effort.

42. Exhaustion: Death caused by extreme fatigue.

43. Shock: Death caused by a sudden drop in blood pressure.

44. Anaphylaxis: Death caused by a severe allergic reaction.

45. Septic shock: Death caused by a severe infection.

46. Organ failure: Death caused by the failure of a vital organ.

47. Multiple organ failure: Death caused by the failure of multiple organs.

48. Coma: Death caused by a prolonged state of unconsciousness.

49. Vegetative state: Death caused by a state of permanent unconsciousness.

50. Brain death: Death caused by the irreversible cessation of brain function.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16833		Items #13 & 14 Film #5387-14/1/67-26						16832			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> d. STREET ADDRESS <u>Route 32</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MINNIE BETSETTA ROEHN</u> First <u>Desetta</u> Middle <u>ROEHN</u> Last <u>ROEHN</u>						4. DATE OF DEATH <u>Dec. 25th</u> 19 <u>66</u> . Month <u>Dec.</u> Day <u>25th</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Can.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-28-47</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Charles /Ritzins/ Ritzius</u>						14. MOTHER'S MAIDEN NAME <u>Annie Leigheiser Lighthiser</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Charles Hoddinott</u>			Address <u>28 Delrey Avenue 28</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Ischaemic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13th</u> , 19 <u>66</u> , to <u>Dec 25th</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 25th</u> 19 <u>66</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>M. I. MacGregor</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GREGOR</u>						22b. DATE SIGNED <u>Dec. 25th, 1966</u>					
22d. ADDRESS <u>Greater Baltimore Med. Centre</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/28/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Woodlawn, Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. J. Fickner &amp; Son</u>						25a. REC'D BY REGISTRAR <u>Balto. 1st</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
						DATE <u>DEC 27 1966</u>					

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Other constant variables were

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16834

CERTIFICATE OF DEATH

16833

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3403 E. White Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY ALICE ROFF</b> First Middle Last 4. DATE OF DEATH <b>December 15, 1966</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Jan. 16, 1869</b> 9. AGE (In years last birthday) <b>97</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jesse K. Hall</b> 14. MOTHER'S MAIDEN NAME <b>Annie Kellan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>220-46-6777 T</b> 17. INFORMANT <b>Mr. J. Nelson Roff, 224 E. 22nd. St. Balto.</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro vascular accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCVD</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>SEP 1, 1963</b> to <b>DEC 15, 1966</b> that (I) (we) lost the deceased alive on <b>DEC 15, 1966</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above. 22a. SIGNATURE <b>James E. Rowe</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>JAMES E. ROWE</b> 22d. ADDRESS <b>CATONSVILLE MD. 21228</b> 22b. DATE SIGNED <b>12/16/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>12/17/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b> ADDRESS 25a. REC'D BY REGISTRAR <b>DEC 19 1966</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16835  
16834  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor 21222</b> c. LENGTH OF STAY IN lb <b>14 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>206 Oakwood Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor 21222</b> d. STREET ADDRESS <b>206 Oakwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES SHERMAN ROSE</b> First Middle Last 4. DATE OF DEATH <b>December 23rd, 1966</b> Month Day Year				9. AGE (In years last birthday) <b>14</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/8/1952</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Robert F. Rose</b>			
14. MOTHER'S MAIDEN NAME <b>Viola Rozell</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Robert F. Rose,</b> Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Musclar Dysdrotrophy, Dystrophy</b> 749.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>Dec</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov. 9</b> , 19 <b>66</b> and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>B.W. Sollod</b>				22b. DATE SIGNED <b>12/24/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>B.W. Sollod, M.D.</b>				22d. ADDRESS <b>2900 Dunran Road, Dundalk, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Dorsey, Maryland</b>	
24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Milford Manor Nursing Home</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>					d. STREET ADDRESS <u>3501 St. Paul St.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>-</u> Last <u>Rosenberg</u>			4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-1911</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Louis Cohen</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Levinson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-26-7873</u>		17. INFORMANT <u>Mr. Sidney Cohen, 3501 St. Paul Street</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>12 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25</u> , 19 <u>65</u> , to <u>Dec 29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 29</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Manuel Levin</u>								22b. DATE SIGNED <u>12/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>				22d. ADDRESS <u>4818 Reisterstown Rd</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sub. Gerson &amp; Bros</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>JAN 4 1967</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film G384 1/5/67 mh

16837

CERTIFICATE OF DEATH

16837

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yrs. 57dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville Baltimore</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>3104 Auchentoroly Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>S</b> Last <b>Rost</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-80</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse L P N</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Philip Rost</b>				14. MOTHER'S MAIDEN NAME <b>Whilhemina Baum</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>219-54-3402</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Heart Disease</b> DUE TO (c) <b>Arteriosclerosis, Generalized, senile</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>4</b> (this hospital) attended the deceased from <b>11-1-61</b> , 19__, to <b>12-27-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>12-27-66</b> , 19__, and that death occurred at <b>10:30</b> pm, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				22b. DATE SIGNED <b>12/28/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>	
22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland 21228</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, BURIAL		23b. DATE THEREOF <b>12-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson</b>				25a. REC'D BY REGISTRAR <b>JAN 3 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16838						16838					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Baltimore</u> MARYLAND						a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>					
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>						d. STREET ADDRESS <u>Cameron Mill Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cameron Mill Rd.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Joshua Rosier</u>						4. DATE OF DEATH <u>December 27 1966</u>					
5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>May 18 1893</u> 9. AGE (In years last birthday) <u>73</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Paper</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>White Hall, Md</u>						12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Unknown.</u>						14. MOTHER'S MAIDEN NAME <u>Dora Rosier</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>220-07-7994</u>					
17. INFORMANT <u>Norris Rosier</u>						Address <u>Cockeysville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u>											
1538 DUE TO (b) <u>primarily in colon, jaundice,</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>etc</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>64</u> , to <u>Dec.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 22 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Norman H. Gemmill</u>						22b. DATE SIGNED <u>12-29-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill</u>						22d. ADDRESS <u>Shrewsbury, Pa.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Dec. 30, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stablers Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Parkton, Md.</u>	
24. FUNERAL DIRECTOR <u>Isaac Kastenbaum</u>						25a. REC'D BY REGISTRAR <u>Isaac Kastenbaum</u>					
25b. REGISTRAR'S SIGNATURE <u>Isaac Kastenbaum</u>						DATE <u>JAN 3 1967</u>					



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16839

CERTIFICATE OF DEATH

16838

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randa Island</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u> <u>031</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK E Rowley</u>		4. DATE OF DEATH Month Day Year <u>12-22-1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-90</u>
9. AGE (In years lost birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>12-22-1966</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Albright</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Porter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hosp. Record</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic HEART DISEASE</u> DUE TO (c) <u>HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-18-1966</u> , to <u>12-22-1966</u> , that (I) (we) last saw the deceased alive on <u>12-22-1966</u> , and that death occurred at <u>1230AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. A. Plentino</u>		22b. DATE SIGNED <u>12-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIANO A. PLENTINO</u>		22d. ADDRESS <u>5731 Summer Ave. 21215</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D. BY REGISTRAR <u>1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16840						16839					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson, Md 21204</u> d. STREET ADDRESS <u>905 Tanway Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>W</u> Last <u>Royce</u>						4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02-1-19</u>		9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN-Marietta</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Wm Royce</u>						14. MOTHER'S MAIDEN NAME <u>SWENSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>372-16-8668</u>		17. INFORMANT <u>Admission CHART</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE GASTRIC HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RETICULUM CELL SARCOMA, DISSEMINATED</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 4th</u> , 19 <u>66</u> , to <u>Dec. 19th</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 19</u> , 19 <u>66</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>M. I. MacGregor</u>						22b. DATE SIGNED <u>12-19-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GREGOR</u>						22d. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12.22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>					
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>						25a. REC'D BY REGISTRAR <u>DEC 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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10833

Baltimore, Md.

Green Mount

12.22.1968

Yonkers, Md. 21204

Yonkers, Md. 21204

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16841

**CERTIFICATE OF DEATH**

16840

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>2yr5mth2ldys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>7100 River Drive Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise (Rydziewski) Rydzewski</b>				4. DATE OF DEATH Month Day Year <b>December 27 19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 15, 1888</b>		9. AGE (In years (ann birthday) yrs. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b>	
13. FATHER'S NAME <b>Joseph Barnas</b>				14. MOTHER'S MAIDEN NAME <b>Mary BIELOTOWICZ</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>216-34-2263</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 DEHYDRATION - MALNUTRITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</b> (c) <b>GENERALISED ARTERIO SCLEROSIS (SEVERE)</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>as</del> (this hospital) attended the deceased from <b>July 1</b> , 19 <b>64</b> , to <b>Dec 27</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Dec 27</b> , 19 <b>66</b> , and that death occurred at <b>3:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Stella Wachslar</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>				22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. Co. MD.</b>	
24. FUNERAL DIRECTOR <b>W. FIALKOWSKI</b>				ADDRESS <b>2007 EASTERN AVE.</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>W. Fialkowski</b>		<b>BALTO-21231 MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>																					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>												c. LENGTH OF STAY IN 1b <u>03.1</u>																					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>520 Hampton Lane</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>Sack</u>												4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1966</u>																					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/16/1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>Herman Gleitsman</u>												14. MOTHER'S MAIDEN NAME <u>Margaret A. Koppelman</u>																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>												16. SOCIAL SECURITY NO. <u>220-44-2944</u>		17. INFORMANT <u>Mrs. Margaret E. Stillings</u> Address <u>(Same)</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperventilation</u> DUE TO (b) <u>Muscular Dystrophy</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>15 years</u>																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																					
21. I certify that (I) (this hospital) attended the deceased from <u>July 22</u> , 19 <u>65</u> , to <u>Dec. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 27</u> , 19 <u>66</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.																																	
22a. SIGNATURE <u>L. Myrton Gaines Jr.</u>												22b. DATE SIGNED <u>December 29, 1966</u>																					
22c. PHYSICIAN'S NAME (Type) <u>Dr. L. Myrton Gaines, Jr.</u>												22d. ADDRESS <u>7800 York Road</u>																					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/31/1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>				23d. LOCATION (City, town or county) (State) <u>Parkville, Balto. Co., Md.</u>																					
24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>												25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>												25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

16841

34281

*Monoclonal Antibody*  
*Pyrophosphate*

12 years

*Pyrophosphate*

10.27 66

July 22

22 Nov 28

24

12 years

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16843

CERTIFICATE OF DEATH

16842

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>3325 Parktowne Rd. 21234</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>J.</b> Last <b>Sahlender</b>				4. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/31/97</b>	
9. AGE (In years lost birthday) <b>68 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Wenceslaus Klinka</b>			
14. MOTHER'S MAIDEN NAME <b>Maria Koslohr Ritz</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>217-20-3334A</b>				17. INFORMANT <b>Bobby A. Schroeder</b> Address <b>3325 Parktowne Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/9/66</b> , 19 <b>66</b> , to <b>12/6</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>12/6</b> , 19 <b>66</b> , and that death occurred at <b>6:20 P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>12/6/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Nelson A. Villamor M.D.</b>	
22d. ADDRESS <b>St. Joseph Hospital</b>				22e. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-10-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Philip F. Crach 1211 Chesaco Ave</b>				25a. REC'D BY REGISTRAR <b>DEC 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 Film G384 1/5/67 mh

16844

CERTIFICATE OF DEATH

16843

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21212</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore Co</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>417 Murdock Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard</b> First Middle Last <b>SANFORD</b>		4. DATE OF DEATH Month Day Year <b>December 30, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commission Mcht.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Same</b>	
13. FATHER'S NAME <b>Richard E. Sanford</b>		14. MOTHER'S MAIDEN NAME <b>Jetter Louise Sisson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-1960</b>	
17. INFORMANT <b>Mrs. Mary Grace Sanford</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <b>12/27/</b> , 19 <b>66</b> , to <b>12/30/</b> , 1966, that (X) (we) last saw the deceased alive on <b>12/30/</b> , 19 <b>66</b> , and that death occurred at <b>11:40</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>12/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove United Brethren Parkton, Md.</b>	
23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc</b> <b>6500 York Road Baltimore, Md. 21212</b>	
25a. REC'D BY REGISTRAR <b>JAN 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16845

CERTIFICATE OF DEATH

16844

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>211 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>BER K</b> Last <b>SAWYER</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 19, 1891</b>
9. AGE (In years lost birthday) <b>75 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE MAN</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>SEARS &amp; ROEBUCK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CHICAGO, ILL</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN S. SAWYER</b>	
14. MOTHER'S MAIDEN NAME <b>MARY FULLER</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW I</b>	
16. SOCIAL SECURITY NO. <b>218 07 17 75</b>		17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONset <b>MINUTES</b> <b>OLD &amp; RECENT</b> <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES MELLITUS</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MAY 13</b> , 19 <b>66</b> , to <b>DEC 10</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 10</b> , 19 <b>66</b> , and that death occurred at <b>5:15 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>		22b. DATE SIGNED <i>12/14/66</i>	
22c. PHYSICIAN'S NAME (Type) <b>SHELDON E. KALMUTZ, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/14/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b>		25. REC'D BY REGISTRAR DATE <b>DEC 13 1966</b>	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



18845

10241

CERTIFICATE OF DEATH

DECEASED

NAME

DATE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE

SEX

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16846

CERTIFICATE OF DEATH

16845

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b>				c. LENGTH OF STAY IN 1b <b>03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>19 Waugh Ave.</b>				d. STREET ADDRESS <b>19 Waugh Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Michael</b> Middle <b>Bernard</b> Last <b>Scholtes</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1920</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner Scholtes Iron Workes</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Michael B. Scholtes</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Anderson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-12-9421</b>		17. INFORMANT Address <b>Mrs. Elizabeth W. Scholtes Glyndon, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crownary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>63</b> , to <b>December 12</b> , 19 <b>66</b> ; that (I) (we) last saw the deceased alive on <b>December 10</b> , 19 <b>66</b> , and that death occurred at <b>7:30 P.M.</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>Clarence E. McWilliams</b>				22b. DATE SIGNED <b>12-13-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Reisterstown Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Towson Md.</b>	
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>	

1024

1024

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1024

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16847

CERTIFICATE OF DEATH

16846

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 1b <u>24 DAYS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen Hosp</u>				d. STREET ADDRESS <u>3209 Southgreen Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Irwin Schrum</u>				4. DATE OF DEATH <u>12 30 19 66</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-37</u>	
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Sam Schrum</u>				14. MOTHER'S MAIDEN NAME <u>Gallon, Sarah</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>219-32-4788</u>		17. INFORMANT <u>Chart, Mrs. Myrna Schrum</u> Address <u>green Rd. 3209 South-</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>190.9</u> IMMEDIATE CAUSE (a) <u>MALIGNANT MELANOMA WITH METASTASIS</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-27-66</u> , 19 <u>66</u> , to <u>12-30-66</u> , that (I) (we) last saw the deceased alive on <u>12-30-66</u> 19 <u>66</u> , and that death occurred at <u>3:30A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Morton Elin/O'maj</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. MORTON ELLIN</u>				22d. ADDRESS <u>BALTIMORE COUNTY HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bnai Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>				25a. REC'D BY REGISTRAR <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

16841

OFFICE OF THE DEAN

16841

TO THE DEAN OF THE UNIVERSITY OF CALIFORNIA  
FROM THE DEAN OF THE UNIVERSITY OF CALIFORNIA  
SUBJECT: [illegible]  
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>16848</p> </div> <div> <p>STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>16847</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>2530 Washington Blvd</u>					
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First Middle Last						4. DATE OF DEATH <u>Dec. 15</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wk</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/28/1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OVERALLS</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SYLVESTER ALBRECHTS</u>						14. MOTHER'S MAIDEN NAME <u>BLAIR</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-01-2629A</u>				17. INFORMANT <u>Raymond J. Schwartz - 2530 Washington Blvd</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>331X Atherosclerotic aneurysm</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1. day</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2 Dec.</u> 19 <u>66</u> , to <u>15 Dec.</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>15 Dec.</u> 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William Goodman, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>16 Dec 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, MD</u>						22d. ADDRESS <u>4334 Sulphur Spring Rd 2122</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Beeto MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kearney</u> ADDRESS <u>1600 Holmes St</u>						25a. REC'D BY REGISTRAR <u>DEC 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

18848

18848



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16849

CERTIFICATE OF DEATH

16848

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>Baltimore City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>325 Calhoun Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Esther Scott</b>		4. DATE OF DEATH Month Day Year <b>Dec. 11 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Eastern Shore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert R. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Annie Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-54-3416</b>	
17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT.</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>JULY 22</b> , 19 <b>65</b> , to <b>DEC. 11</b> , 19 <b>66</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>DEC. 11</b> , 19 <b>66</b> , and that death occurred at <b>12:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>12/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Deasedit J. G. Bitardo</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>12-15-66</b>	23c. NAME OF CEMETERY OR-CREMATORY <b>B Nat Cem</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto Md</b>
24. FUNERAL DIRECTOR <b>Charles Wilson</b> <b>1000 Brantley Ave</b>		25a. REC'D BY REGISTRAR <b>DEC 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1034

UNITED STATES DEPARTMENT OF JUSTICE

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16850

16849

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21204</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>						d. STREET ADDRESS <u>919 Dulaney Valley Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Robert Brent Scott</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>December 28 19 66</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16 1906</u>		9. AGE (In years last birthday) <u>60</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Engineering</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert Brent</u>						14. MOTHER'S MAIDEN NAME <u>Laura Barnes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Family Records</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Pulmonary Edema</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <u>Dec. 28</u> , 19 <u>66</u> , to <u>Dec. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 28</u> , 19 <u>66</u> , and that death occurred at <u>7:06 PM</u> , from causes and on the date stated above.										
22a. SIGNATURE <u>Elmo M. Gayoso</u>						22b. DATE SIGNED <u>Dec. 28 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>Elmo M. Gayoso</u>	
22d. ADDRESS <u>7620 York Rd. Baltimore, Md. 21204</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Dec. 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memorial Chns.</u>			23d. LOCATION (City or Town) (County) (State) <u>Cockeysville Md.</u>		
24. FUNERAL DIRECTOR <u>John Burns Sons, Towson, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1041

STATE OF DEATH

10220

THE STATE OF DEATH  
IN THE COUNTY OF  
OF THE STATE OF  
IN THE YEAR OF  
1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16851

CERTIFICATE OF DEATH

16850

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD, MARYLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD THEODORE SEIFERT</b>				4. DATE OF DEATH Month Day Year <b>12 23 19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 14 1899</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONST. SUPERINTENDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ADAM SEIFERT</b>				14. MOTHER'S MAIDEN NAME <b>KATHRYN Dietzel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>215 09 13 24A</b>		17. INFORMANT Address <b>CLINICAL RECORDS-VAH FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA LEFT LUNG, MALIGNANT WITH METASTASES TO RIGHT LUNG AND LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROSIS, GENERALIZED AND BRONCHOPNEUMONIA, BILATERAL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>12 19 1966</b> to <b>12 23 19 66</b> that <del>XX</del> (we) last saw the deceased alive on <b>12 23 19 66</b> , and that death occurred at <b>8:20 AM</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>J. D. Talbert</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12 23 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M.D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-27-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>HOWARD H. HUBBARD</b>				ADDRESS <b>4107 Wilkens Ave</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.

10801

10801

NOT CHECKED ON VENDOR'S ACCOUNT  
13 JANUARY 1964  
10 JANUARY 1964  
10 JANUARY 1964  
10 JANUARY 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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16852

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN Tb <u>20 DAYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d. STREET ADDRESS <u>3906 BONNER RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SELDEN</u> Last <u>FRANKEL</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-10-84</u> 9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HARRY FRANKEL</u> 14. MOTHER'S MAIDEN NAME <u>FANNY ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT Address <u>Hospital Record</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>gross pulmonary embolism</u> DUE TO (b) <u>thrombosis</u> DUE TO (c) <u>generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF STOMACH</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-18-1966</u> , to <u>12-7-1966</u> , that (I) (we) last saw the deceased alive on <u>12-7-1966</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>de Jager</u>		22b. DATE SIGNED <u>12-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. de Soyza</u>		22d. ADDRESS <u>Balto county Gen. Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ohr Knesseth Israel Anshe Sfard</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>		25a. REC'D BY REGISTRAR <u>DEC 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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JAN 10 1985  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16853

## CERTIFICATE OF DEATH

16852

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXXXX</del> RANDALLSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>30.4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>				d. STREET ADDRESS <del>XXXXXXXXXXXX</del> <u>3600 Oakmont Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida</u> <del>XXXXXXXX</del> <u>Selesky</u>				4. DATE OF DEATH Month Day Year <u>12</u> <u>11</u> <u>19 66</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <del>XXXXXXXX</del>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>XXXXXXXXXXXX</del>		10b. KIND OF BUSINESS OR INDUSTRY <del>XXXX</del> GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Selesky</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Lubin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-2014</u>		17. INFORMANT Address <u>Mr. Albert Selesky, 3600 Oakmont Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer metastatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Primary site unknown</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>66</u> , to <u>12/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> , 19 <u>66</u> , and that death occurred at <u>6 P.</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Patricia M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GRACIO P. PATRICIO</u>				22d. ADDRESS <u>BC 94</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Isaac Adath Israel</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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16854

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>811 Powers Street</b>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>LEROY</b> Last <b>SHAFFER</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/02</b>
9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Annie A. Nusbaum</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>214-03-17-24</b>	
17. INFORMANT <b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG LEFT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 22</b> , 19 <b>66</b> to <b>Dec. 26</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 26</b> , 1966, and that death occurred at <b>10:58 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED <b>12/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/30-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Frank W. Sitz Funeral Home Baltimore, Maryland</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13824

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16855 16854

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN ID <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b> 23.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>26 Featherbed Lane</b>				d. STREET ADDRESS <b>26 Featherbed Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harvey Duvall Sharon</b>		First Middle Last		4. DATE OF DEATH <b>December 6 1966</b>		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1900</b>		9. AGE (In years last birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Venitian Blinds</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph W. Sharon</b>				14. MOTHER'S MAIDEN NAME <b>Flora Hare</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-9327</b>		17. INFORMANT <b>Mrs. Ora G. Sharon</b>		Address <b>26 Featherbed Lane Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>none</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <b>12-8-66</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		Address (Street, city, town, or county) <b>6 Hanover Rd. Reisterstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/8/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR <b>H. J. Schardt</b>				ADDRESS <b>Owings Mills, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 9 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16856

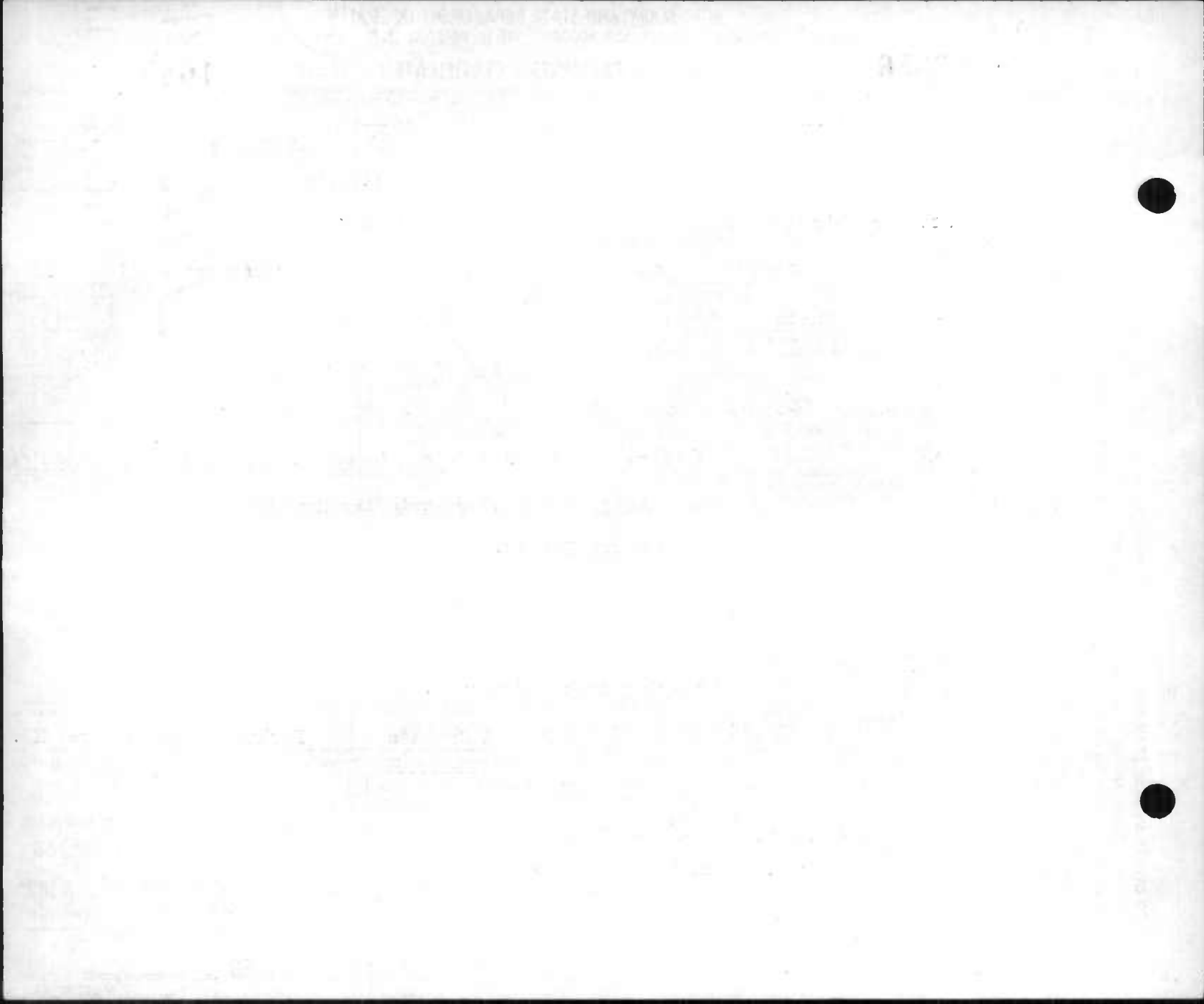
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16855

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d. STREET ADDRESS <b>8442 Oakleigh Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>HENRY</b> Last <b>SHARP</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-12-1946</b>
9. AGE (In years last birthday) yrs. <b>20</b>		10. IF UNDER 1 YEAR Months <b>20</b> Days <b>11</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH HENRY SHARP</b>		14. MOTHER'S MAIDEN NAME <b>ALMA EDITH SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-46-1145</b>	
17. INFORMANT <b>JOSEPH H. SHARP SR. 8442 OAKLEIGH RD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid and Intraventricular Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blunt Force Injury.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Playing tackle football.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12/ 11 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>School Grounds</b>		20f. (City or town) (County) (State) <b>Parkville Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		22. DATE SIGNED <b>12/12/66</b>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO CO. MD.</b>
24. FUNERAL DIRECTOR <b>John E. Johnson</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
ADDRESS <b>8521 Locust Rowan Rd</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16857

16856

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK AVE.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>59 ADMIRAL BLVD.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>BALTO.</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> d. STREET ADDRESS <u>59 ADMIRAL BLVD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>GEORGE R. JHEESLEY</u>		<b>4. DATE OF DEATH</b> Month <u>DEC.</u> Day <u>25</u> Year <u>1966</u>		<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1 MAY 1901</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HEATER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>JTEEL</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PENNSYLVANIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> <u>GRANT JHEESLEY, 63 ADMIRAL BLVD. 21222</u> Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>1/22/1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MAY 1960</u> <b>to</b> <u>12/23/66</u> <b>that (I) (we) last saw the deceased alive on</b> <u>12/23/66</u> <b>and that death occurred at</b> <u>8:30 AM</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>W. E. BAERMANN</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. E. BAERMANN</u>						<b>22d. ADDRESS</b> <u>3401 DUNDALK AVE.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>12-26-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MEADOW RIDGE</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>HOWARD COUNTY, MD.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>CLERICH FUNERAL HOME, DUNDALK, MD.</u> ADDRESS						<b>25a. REC'D BY REGISTRAR</b> <u>DEC 30 1966</u> DATE		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16858

CERTIFICATE OF DEATH

16857

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Cockeysville</del> <b>Phoenix</b> c. LENGTH OF STAY IN 1b <b>4 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sunnybrook &amp; Paper Mill Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b> d. STREET ADDRESS <b>Sunnybrook &amp; Paper Mill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>I.</b> Last <b>Shubkagel</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1889</b> 9. AGE (In years lost birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>William H. Shubkagel</b>		14. MOTHER'S MAIDEN NAME <b>Clara M. Boll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-8764A</b>	
17. INFORMANT <b>Mr. William B. Stonesifer</b>		Address <b>Sunnybrook &amp; Paper Mill Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intox Alcoholis CardioVas Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/20</b> , 19 <b>66</b> , to <b>12/22</b> , 19 <b>66</b> ; that (I) (we) last saw the deceased alive on <b>12/20</b> , 19 <b>66</b> , and that death occurred at <b>5A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>C. Herbert Mueller</b>		22b. DATE SIGNED <b>12/22/66</b>	22c. PHYSICIAN'S NAME (Type) <b>C. HERBERT MUELLER JR</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>21204 York Rd. Baltimore, Maryland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16859

## CERTIFICATE OF DEATH

16858

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6522 GOLDEN RING RD.</u>				d. STREET ADDRESS <u>6522 GOLDEN RING RD.</u>			
3. NAME OF DECEASED (Type or print) <u>MAMIE (MARY) M. SIFFORD (GROSS)</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HUBER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4/20/10</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>12</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/19/66</u> , 19 <u>  </u> , to <u>12/23</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>12/19/66</u> , 19 <u>  </u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. J. Lyden</u>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/24/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. J. LYDEN, M.D.</u>		22d. ADDRESS <u>6402 GOLDEN RING RD. BALTIMORE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-27-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Garth Miller - 2334 Jefferson St.</u>				25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



10827

10827

DEC 28 1906

FOR STATE  
HEALTH DEPT

16860

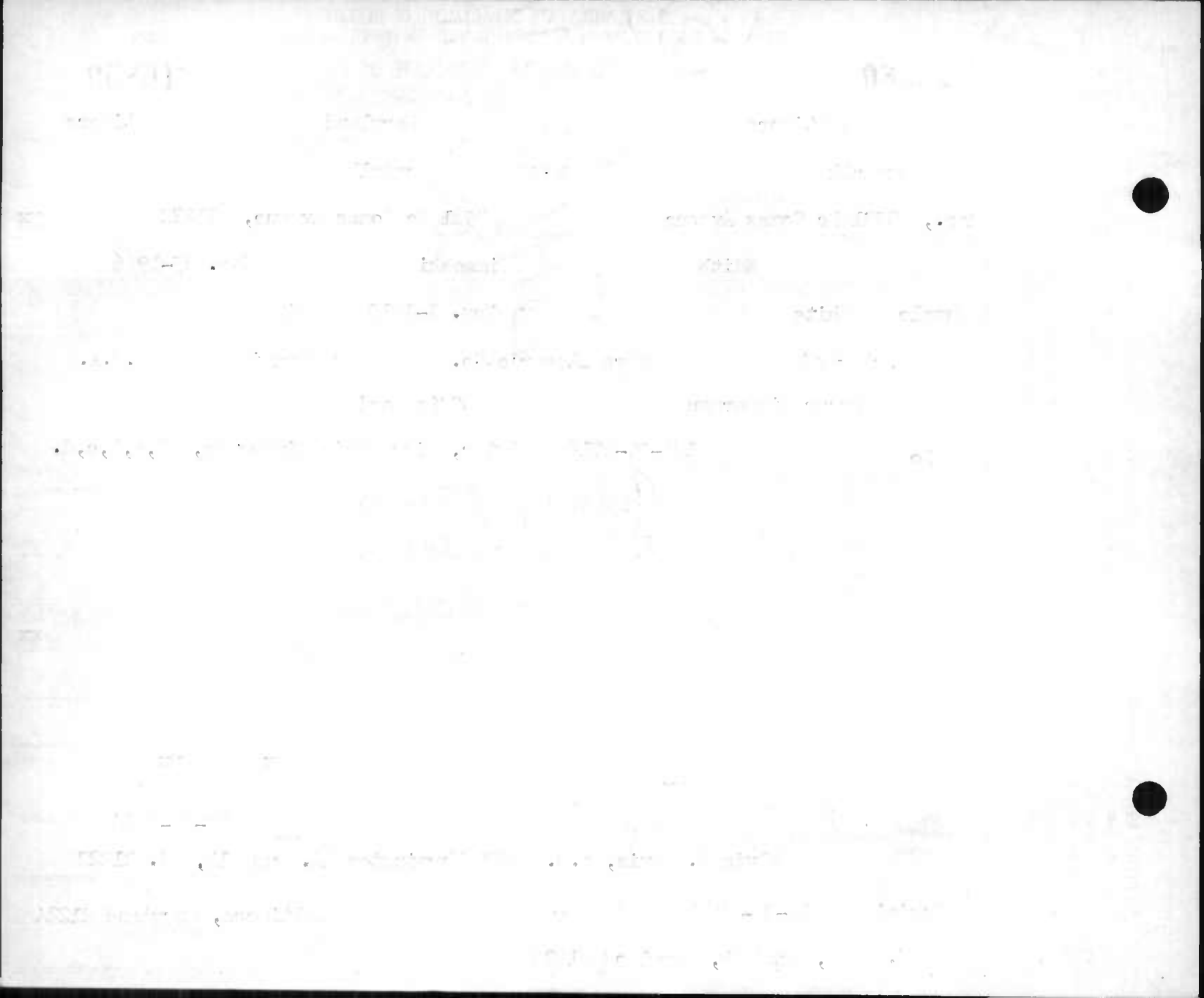
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16859

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 2521 Mc Comas Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Simanski</b> Last <b>Simanski</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1-1915</b>
9. AGE (In years last birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bench Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oscar Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Effie Reed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>188-07-2716</b>	
17. INFORMANT <b>Sister, Miss Elsie Zimmerman, #2, a, b, c, d.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Ascl. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ascl. Disease</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <b>12-26-1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-28-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland 21224</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25a. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>	

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 2 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16861

16860

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3yr5mth5dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marie Isabel Simering</b>		4. DATE OF DEATH Month Day Year <b>December 21 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-90</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Woodstock, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>	
13. FATHER'S NAME <b>John D. Simering</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Cleary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>705-03-7378</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brochopneumonia, organism undetermined</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Heart Disease</b>		INTERVAL BETWEEN ONSET OF DEATH <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>7-16-63</b> , 19 to <b>12-21</b> , 19 <b>66</b> , that (X) (we) lost the deceased alive on <b>12-21</b> , 19 <b>66</b> , and that death occurred at <b>3:00</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young M.D.</i>		22b. DATE SIGNED <b>12-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>Spring Grove State Hospital Catonsville, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-24-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>3801 Frederick Ave. Balto. Md</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13881

CENTRAL ON DEATH

13881

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Howard

Howard

Howard

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12-1-55

White

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12-1-55

78

12-1-55

Howard

13881

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

16862

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16861

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN 1b <b>20 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>NEWPORT NEWS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1133, 22ND STREET</b> d. STREET ADDRESS <b>1133, 22ND STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JESSE SIMKINS</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>31</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 23, 1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>LEESVILLE, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM SIMKINS</b>		14. MOTHER'S MAIDEN NAME <b>LELIA NOTTINGHAM</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>225 18 7613</b>	
17. INFORMANT <b>CLINICAL RECORDS</b>		Address <b>FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL BRONCHIAL PNEUMONIA</b> DUE TO (b) <b>FRACTURED SUPRACONDYLAR RIGHT HIP</b> DUE TO (c) <b>9000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FELL DOWN STEPS AT HOME OF SON</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>48 HOURS</b> <b>21 DAYS</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12-10</b> 19 <b>66</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SONS HOME</b>		20f. (City or town) (County) (State) <b>BALTIMORE, 36 MARYLAND</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>MELVIN B. DAVIS, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>6800 MORNINGTON RD. DUNDALK, MD.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12/31/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/4/67</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CAPE CHARLES CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CAPE CHARLES, VIRGINIA</b>	
23. FUNERAL DIRECTOR <b>FOX FUNERAL HOME</b>		ADDRESS <b>TEMPERANCEVILLE, VIRGINIA</b>	
24a. REC'D BY REGISTRAR <b>JAN 4 1967</b>		24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

13865

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1922, 1923, 1924

WILLIAM J. HARRIS

1922, 1923, 1924

1922, 1923, 1924

1922, 1923, 1924

1922, 1923, 1924

1922, 1923, 1924

1922, 1923, 1924

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1922, 1923, 1924



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16863

16862

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1459 Dartmouth Avenue</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #34 03.1</b> d. STREET ADDRESS <b>1459 Dartmouth Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>LAURA E. SIMPSON</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>December 15, 1966</b> Month Day Year				
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 13, 1888.</b>	<b>9. AGE</b> (In years last birthday) <b>78</b> yrs.	<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Maryland</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>			
<b>13. FATHER'S NAME</b> <b>Henry F. Hoffmann</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura E. Bentz</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>215-54-0678</b>		<b>17. INFORMANT</b> Address <b>Mrs. Sylvia E. McKenzie (Same)</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from <u>May 28, 1965</u>, to <u>Dec. 15, 1966</u>, that (I) (we) last saw the deceased alive on <u>Dec. 14, 1966</u>, and that death occurred at <u>9:30 AM</u>, from causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Carl F. Benson MD</b>			<b>22b. DATE SIGNED</b> <b>Dec. 16, 1966</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Carl F. Benson MD</b>		
<b>22d. ADDRESS</b> <b>5111 York Rd. Balto. Md.</b>			<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>12/19/66.</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>Baltimore, Md.</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			<b>25a. REC'D BY REGISTRAR</b> DATE <b>DEC 19 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16803

CENTRAL OF ALABAMA

16803

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. Page 5 to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16864

16863

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>	
c. LENGTH OF STAY IN 1b <b>1 Day</b>		d. STREET ADDRESS <b>3605 Briarstone Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chapel Hill Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nellie Sims</b>		4. DATE OF DEATH <b>Dec. 16 19 66</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/6/1892</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Hastings</b>		14. MOTHER'S MAIDEN NAME <b>Clara Dunlap</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>274-01-6203</b>	
17. INFORMANT <b>Louise Sims Miller</b>		Address <b>3605 Briarstone Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral</b> DUE TO (b) <b>staphylococcus aureus, coagulase pos.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>two weeks</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic heart disease, generalized arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 16 19 66</b> to <b>Dec 16 19 66</b> that (I) (we) last saw the deceased alive on <b>Dec 16 19 66</b> and that death occurred at <b>9:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank C. Caguin</b>		22b. DATE SIGNED <b>Dec. 16, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>FEODOR C. CAGUIN, M.D.</b>		22d. ADDRESS <b>8811 LIBERTY ROAD, RANDALLSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12 19 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill</b>		23d. LOCATION (City, town or county) <b>Oden, Indiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
ADDRESS <b>8728 Liberty Rd. Randallstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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George J. Hart

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FERDINAND C. CAGAN, MD 8811 LIBERTY ROAD, RANDALLS CENTER, MD

For more information, contact the National Library of Medicine at 800-352-6321 or <http://www.nlm.nih.gov>.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16865

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16864

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> <del>KMOCK</del>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 21214</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>1912 Hillenwood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAE GERTRUDE NEATHERY SKILLMAN</b>				4. DATE OF DEATH Month Day Year <b>December 26, 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7, 1907</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>	
13. FATHER'S NAME <b>Ransom Neathery</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-16-7838</b>		17. INFORMANT Address <b>Mr. Robert L. Skillman-1912 Hillenwood Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>174</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>				22. DATE SIGNED <b>12/26/66</b>			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
16866					16863				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>03.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>					d. STREET ADDRESS <u>3326 Northmont Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Sless</u> Last			4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 6, 1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Berkow</u>					14. MOTHER'S MAIDEN NAME <u>Bessie ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. Elliot J. Sless</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Arteriosclerotic CVD</u> DUE TO (c) <u>Several years</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1966</u> to <u>Dec 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 1966</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard Kotz</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/31/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leonard Kotz</u>					22d. ADDRESS <u>11 Slade Avenue</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anshe Emunah - (Aitz Chaim)</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>					25a. REC'D BY REGISTRAR <u>JAN 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<p>1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b></p> <p>c. LENGTH OF STAY IN 1b <b>8 DAYS</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PR. GEO. HGT.</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Capitol Hgts. FARMINGTON MD 1612</b></p> <p>d. STREET ADDRESS <b>807 61st.</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
3. NAME OF DECEASED (Type or print) <b>HARRY ANDREW SMALL</b>			4. DATE OF DEATH <b>12 9 1966</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-16-83</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Not Known</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SHEET METAL</b>				11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JOSEPH SMALL</b>								14. MOTHER'S MAIDEN NAME <b>MARtha BROWN</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>579-18-074</b>				17. INFORMANT <b>PATIENT'S CHART</b> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992 Respiratory obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of oral-facial region</b> (c) <b>region</b>																INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.																			
22a. SIGNATURE <b>Edgar A. Gedock</b> M.D.												22b. DATE SIGNED <b>12-9-66</b>							
22c. PHYSICIAN'S NAME (Type) <b>Edgar A. Gedock</b>												22d. ADDRESS <b>Balto. Medical Ctr. Balto. MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>12/12/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				23d. LOCATION (City, town or county) (State) <b>PR. GEO. CO. MD.</b>							
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. 517 11th St SE</b>												25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

16868

16867

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>3419 ELMORA AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>VERNON</b> Middle <b>C.</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/14/03</b>
9. AGE (In years lost birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NIGHT WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kodak Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE N. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>EMMA T. JOHN SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>212 07 20 64</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Generalized Metastasis of Carcinoma of Lung</b> DUE TO (b) <b>( Left )</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/22/63</b> , 19 <b>63</b> , to <b>12/5/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/5/66</b> , 19 <b>66</b> , and that death occurred at <b>3:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L. B. STEVENS</b>		22b. DATE SIGNED <b>12/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. B. STEVENS, M. D.</b>		22d. ADDRESS <b>3400 Erdman Avenue, Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>SCHIMMINEK FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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QUESTIONS

**FINE STRUCTURE**

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

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CLARK, J. W. 1963.

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• C. W. DeVries, Jr. •

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (1)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 7 Film G383 12/12/66 mh

16869

CERTIFICATE OF DEATH

16868

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> COUNTY <u>CECILTON</u> <u>MD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> -28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>4409 Alan Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Wm Julian Smith</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/1909</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		9b. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cecilton, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cecilton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Smith, Pickron</u>		14. MOTHER'S MAIDEN NAME <u>Smith, Edith Alderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Anna V. Gent, 4602 Cedar Garden Rd.</u>		18. ADDRESS <u>21229</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Aspiration</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Idiopathic Epilepsy</u> (c) <u>Idiopathic Epilepsy</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-21-1965</u> , to <u>12-6-1966</u> , that (I) (we) last saw the deceased alive on <u>12-6-1966</u> , and that death occurred at <u>8 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Cesar Valle Caverio</u>		22b. DATE SIGNED <u>12-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u>		22d. ADDRESS <u>8629 Liberty Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-9-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cecilton Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cecilton, Md.</u>
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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WASHINGTON, D. C.  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16870 CERTIFICATE OF DEATH 16869

1. PLACE OF DEATH a. COUNTY, <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Towson Nursing Home</b>		d. STREET ADDRESS <b>403 Edgevale Road 10</b>	
3. NAME OF DECEASED (Type or print) First <b>Sue</b> Middle <b>C.</b> Last <b>Snow</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Matron - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Chiles</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Henry W. Snow</b>		Address <b>same address as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1960</b> to <b>Dec. 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 11, 1966</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Laurence C. Post</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		22d. ADDRESS <b>6805 York Rd. - Baltimore 21212 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Fickman &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>Baltimore Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 13 1966</b>	

1955

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London, England

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16871

CERTIFICATE OF DEATH

16870

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9406 Belair Road</u>				d. STREET ADDRESS <u>9406 Belair Road 36</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>R.</u> Last <u>Solomon</u>				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-1887</u>		9. AGE (In years last birthday) <u>79 yrs.</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Solomon</u>				14. MOTHER'S MAIDEN NAME <u>Rosina L. Seiling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-0717</u>		17. INFORMANT <u>Mrs Carrie Solomon 9406 Belair Road 36</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Congestive heart failure</u> DUE TO (c) <u>Advanced Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 23, 1963</u> to <u>Dec 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec 29, 1966</u> , and that death occurred at <u>10:45 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Theodore E. Evans</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. DATE SIGNED <u>12/30/66</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans</u>				22d. ADDRESS <u>9660 Belair Rd. Balto 36, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-2-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Golden Ring Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road 36</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1024

CENTRAL OF FLA

1024

TO ALL THE MEMBERS OF THE BOARD OF DIRECTORS  
OF THE CENTRAL OF FLA  
AT THE ANNUAL MEETING OF THE BOARD OF DIRECTORS  
HOLDING AT THE HOTEL FLORIDA, MIAMI, FLA.  
ON THE 15TH DAY OF DECEMBER, 1924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16872

CERTIFICATE OF DEATH

16872

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>7 HRS-10 MIN.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2444 MC CULLOH STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>--</b> Last <b>SORRELL</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 2, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OYSTERING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>LANCASTER COUNTY, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARVEY SORRELL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA VENIE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>217 03 9037</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Duodenal Ulcer with hemorrhage</b> DUE TO (b) <b>and/or perforation</b> DUE TO (c) <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>hrs. - days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>3:10 PM</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>8:00 AM</b>	20f. (City or town) (County) (State) <b>3:10 PM</b>
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14, 1966</b> , to <b>Dec. 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 14, 1966</b> , and that death occurred at <b>3:10 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Carmelita A. Cendana, M.D.</b>		22b. DATE SIGNED <b>12 14 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARMELITA A. CENDANA, M. D.</b>		22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12-19-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Morton &amp; Dyett</b> <b>1701 Laurens st.</b> <b>Baltimore, Md.</b>		25. REC'D BY REGISTRAR <b>DEC 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16873 CERTIFICATE OF DEATH 16872

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) b. STATE <u>Md.</u> c. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>J. B. M. C. TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Ridgely Rd. LUTHERVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Christopher Harris Souris</u>		d. STREET ADDRESS <u>03-1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTOPHER HARRIS SOURIS</u>		4. DATE OF DEATH Month Day Year <u>Dec 6 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANTEUR - OWNER - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kytheria, Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harris Christopher Souris</u>		14. MOTHER'S MAIDEN NAME <u>BEULAH (?) SOURIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uraemia, anemia, congestive heart failure</u> DUE TO (c) <u>Diabetes mellitus, nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 4</u> , 19 <u>66</u> , to <u>December 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 6</u> 19 <u>66</u> , and that death occurred at <u>5:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>D. Kuwilsky</u>		22b. DATE SIGNED <u>12-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dora C Kuwilsky</u>		22d. ADDRESS <u>Greater Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 9, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREEK ORTHODOX CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WOODLAWN, BALTO. CO., MD.</u>	
24. FUNERAL DIRECTOR <u>John Burns Sons, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 16 1966</u>	



1021

1021



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

16874

16873

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>Towson</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> <b>Towson</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>03.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>914 Register Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>James</b> Last <b>Stevens</b>				4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>19 66</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-66</b>		9. AGE (In years lost birthday) yrs. <b>5</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John A. Stevens</b>				14. MOTHER'S MAIDEN NAME <b>Lois Long</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John A. Stevens -</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing Injury of Skull</b> <b>8130</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of item 18) <b>None</b>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>12301 Register Ave.</b>		20f. (City or town) (County) (State) <b>Baltimore Maryland</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>4:10</b> a.m. <b>12/30/66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>12301 Register Ave.</b>		20f. (City or town) (County) (State) <b>Baltimore Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>12/30/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/2/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Margaret's</b>		23d. LOCATION (City or Town) (County) (State) <b>St. Margaret's, A.A., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 3 1967</b>		25b. REGISTRAR SIGNATURE <b>James Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2-11-1941

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16875

## CERTIFICATE OF DEATH

16874

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1021 NORTH CENTRAL AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>STEWART</b> Last		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>4</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>JUNE 1, 1895</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COPPER PLANT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CAMBRIDGE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FREDERICK STEWART</b>		14. MOTHER'S MAIDEN NAME <b>MOLLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>212 10 16 18</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CLINICAL RECORDS <b>FORT HOWARD, MARYLAND</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X METASTATIC LUNG CANCER</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ANAPLASTIC CANCER ANAL CANAL</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV 14</b> , 19 <b>66</b> , to <b>DEC 4</b> , 19 <b>66</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 4</b> , 19 <b>66</b> and that death occurred at <b>300PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Madhav J. Barhanpurkar</b>		22b. DATE SIGNED <b>12-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MADHAV BARHANPURKAR, M.D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>12/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>LOCKS FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>1300 CENTRAL AVE., BALTIMORE, MARYLAND</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16876 CERTIFICATE OF DEATH 16875

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>9 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> <u>03.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>90 Ridgeway Manor</u>				d. STREET ADDRESS <u>5535 Link Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Annie C. Stockett</u>				4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26, 1978</u>	9. AGE (in years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>B. Brady</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mabel McKinley</u> Address <u>5535 Link Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 331X DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Right eye.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>Dec 15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 15 1966</u> , and that death occurred at <u>430 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Goodman</u>				22b. DATE SIGNED <u>17 Dec 66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. William Goodman</u>	
22d. ADDRESS <u>1934 Sulphur Spring Rd</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery Baltimore, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Ambrose, Inc 1928 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			

MEDICAL CERTIFICATION

1023

CERTIFICATE OF DEATH

12820



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16877

## CERTIFICATE OF DEATH

16876

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>22yr11mth28dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Doris</b> Middle <b>F.</b> Last <b>Strauss</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1908</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Abraham Freiman</b>		16. MOTHER'S MAIDEN NAME <b>Fannie Nashalevitz</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>219-05-0518</b>	
19. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>—</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia, organism unknown</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Arteriosclerotic cardiovascular heart disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> o.m. <b>19</b> p.m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Dec. 23, 1966</b> to <b>Dec. 21, 1966</b> , that (X) (we) last saw the deceased alive on <b>Dec. 21, 1966</b> , and that death occurred at <b>1:35</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>12-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/22/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Adath Jeshurun</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</b>		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. Young</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
16878					16877														
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>30-4</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>					d. STREET ADDRESS <u>LAKE AVE. EMERSONIAN APTS., EUTAW</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>BLANCHE</u> First <u>B</u> Middle <u>STROUSE</u> Last			4. DATE OF DEATH <u>DEC.</u> Month <u>9</u> Day <u>19</u> Year <u>1966</u>																
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-27-83</u>		9. AGE (In years last birthday) <u>82</u> yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>BENJAMIN STROUSE</u>					14. MOTHER'S MAIDEN NAME <u>FANNIE KAHN</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-44-0257</u>		17. INFORMANT <u>Mr. Ben Strouse</u>		Address <u>8200 Tall Chimney Ct. Pikesville, Md. 21208</u>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DISEASE</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIVERTICULITIS</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
MEDICAL CERTIFICATION										21. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>66</u> , to <u>12-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-9</u> , 19 <u>66</u> , and that death occurred at <u>6:55</u> P.M., from the causes and on the date stated above.									
										22a. SIGNATURE <u>Evelyn L. Ramos, M.D.</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		
										22c. PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u>					22d. ADDRESS <u>6701 N. Charles St. Balto, Md. 04</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>12/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oheb Shalom</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>											
24. FUNERAL DIRECTOR <u>Wm. J. Pickner &amp; Sons Inc. Balto, Md.</u>					ADDRESS <u>401 Pa. Ave.</u>		25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>										
					DATE <u>DEC 13 1966</u>														

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>Towson</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospice</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b> d. STREET ADDRESS <b>5513 Lothian Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kate A. Suelau</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>17-</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>30.4</b> Days <b>4</b>	11. IF UNDER 24 HRS. Hours <b>4</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Marshall Town, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Neary</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Loftus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>479-09-0644D</b>	
17. INFORMANT <b>obtained from records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b> DUE TO (b) <b>4721</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-20-62</b> , 19 <b>66</b> , to <b>Dec. 17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 17</b> , 19 <b>66</b> , and that death occurred at <b>7:35 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Mahon</b>		22b. DATE SIGNED <b>12/17/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>		22d. ADDRESS <b>204 E. Joppa Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/20/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>4205 York Road Baltimore 12, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>Item 12 Film G384 12/28/66 mh</div> <div>16879</div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore 21223</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>						d. STREET ADDRESS <b>52 S. Fulton Ave.</b> <del>5743 Edmondson Avenue</del>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ethel</b>		First <b>Ethel</b>		Middle <b>Maud</b>		Last <b>Summers</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1876</b>		9. AGE (in years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>?</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>William Sanders</b>						14. MOTHER'S MAIDEN NAME <b>Etta</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Paul A. Summers</b> Address <b>same address as above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>4/20/</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe osteoarthritis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>More than 10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (his/her) attended the deceased from <b>12/24/</b> , 19 <b>65</b> , to <b>11/19/</b> , 19 <b>66</b> , that (I) (he) last saw the deceased alive on <b>11/19/</b> 19 <b>66</b> , and that death occurred at <b>6:15</b> M., from the causes and on the date stated above.											
22a. SIGNATURE <b>S. J. Liu</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/16/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>S. J. Liu, M. D.</b>						22d. ADDRESS <b>5301 Harford Road Balto., Md. 21214</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. J. Finkner &amp; Sons</b>						25a. REC'D BY REGISTRAR <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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Arteriosclerotic cardiovascular disease

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and at any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Owings Mills		c. LENGTH OF STAY IN 1b		10 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		LaPlata	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Rosewood State Hospital		d. STREET ADDRESS		Star Route 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Agnes		Middle Marie		Last SWANN		4. DATE OF DEATH		Month 12 Day 4 Year 19 66	
5. SEX		Female		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 24 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Dependent		10b. KIND OF BUSINESS OR INDUSTRY		none		11. BIRTHPLACE (County & State, or foreign country)		Charles Co., Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME		Raymond Swann		14. MOTHER'S MAIDEN NAME		Erva Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		no		16. SOCIAL SECURITY NO.		none		17. INFORMANT		Rosewood Records, Owings Mills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Necrotizing Broncho Pneumonia 491X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH		5 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. Hour a.m. p.m.		19		20d. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 10-1 to 12-4, 1966, that (I) (we) last saw the deceased alive on 12-4, 1966, and that death occurred at 8:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE		Harvey M. Solomon M.D.		22b. DATE SIGNED		12-4-66			
22c. PHYSICIAN'S NAME (Type)		Harvey M. Solomon, M.D.		22d. ADDRESS		Rosewood State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		12/7/66		23c. NAME OF CEMETERY OR CREMATORY		St Ignatius	
23d. LOCATION (City, town or county)		Bel Alton, Charles, Md.		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		Charles Judge			
24. FUNERAL DIRECTOR'S SIGNATURE		Archibald Funeral Home, Inc. LaPlata, Md.		24b. ADDRESS		24c. DATE		DEC 12 1966			

18281

2015/5/15

• G.M. • AutoLoc • 8740748

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16882

16881

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 31 Lombardy Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>R.</b> Last <b>(Swift-Girvin)</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23-1880</b>
9. AGE (In years birth day) yrs. <b>86</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Millard Swift</b>		14. MOTHER'S MAIDEN NAME <b>Anna Reed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-0247</b>	
17. INFORMANT <b>Son, Samuel J. Girvin, Dundalk, Md. 21222</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>H-S-C-V-Disease</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis M.D.</b>		6800 Mornington Rd. Dundalk, Md. 21222	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec-12-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Madonna, Maryland</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a. REC'D BY REGISTRAR <b>DEC 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16883

CERTIFICATE OF DEATH

16882

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>559 Main Street</b>		d. STREET ADDRESS <b>559 Main Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Virgie</b> Middle <b>E.</b> Last <b>Tawney</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1892</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Clara Lloyd</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-28-0526</b>	
17. INFORMANT <b>Mr. Earl M. Tawney</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis probably originating in liver</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 18, 1961</b> to <b>Dec. 31, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec. 31, 1966</b> , and that death occurred at <b>11:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Martin E. Strobel</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>1-2-67</b>
22c. PHYSICIAN'S NAME (Type) <b>Martin E. Strobel, M.D.</b>		22d. ADDRESS <b>48 Main St. Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto. Co. Md.</b>
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
25a. REC'D BY REGISTRAR <b>JAN 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED BY CASH

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Handwritten notes and signatures in the bottom section of the document, including a signature on the right side.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

1 3  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

168884

CERTIFICATE OF DEATH

168883

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>3 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARADISE NURSING HOME</u>				d. STREET ADDRESS <u>3625 Fourth St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MARIE TAYLOR</u>				4. DATE OF DEATH Month Day Year <u>DEC. 6, 1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>DEC. 10, 1887</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOLAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-10-5540</u>		17. INFORMANT Address <u>MRS. KULLER 356 Bigley Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334 X</u> DUE TO <u>Multiple Small strokes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arterio sclerosis</u> DUE TO <u>104 yrs.</u> (c) <u>one year.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>one year.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>12/6/66</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/64</u> , 19 <u>64</u> , to <u>12/6/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/6/66</u> and that death occurred on <u>12/6/66</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W E Mc Grath</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W E Mc Grath</u>				22d. ADDRESS <u>1303 Frederick Rd 28</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW Cathedral</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD</u>	
24. FUNERAL DIRECTOR <u>Francis D. Miller 2101 Franklin Ave.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16885 CERTIFICATE OF DEATH 16884

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i> c. LENGTH OF STAY IN 1b <i>3 months</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harren Road</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i> d. STREET ADDRESS <i>Warner Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward King Taylor</i>		4. DATE OF DEATH <i>December 20 1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 March 1881</i>
9. AGE (In years last birthday) <i>85 yrs</i>		IF UNDER 1 YEAR: Months <i>03</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sport manager Crown Cork &amp; Seal</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SA</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Elizabeth New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Curtis Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Watson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-01-0752</i>	
17. INFORMANT <i>Wife - Kathleen</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO <i>Cerebral &amp; General Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>over 54 years</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cancer of Prostate some 2 1/2 years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 1966</i> to <i>Dec 1966</i> , that (I) (we) last saw the deceased alive on <i>20 Dec 1966</i> , and that death occurred at <i>12:01 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter T. Kees</i>		22b. DATE SIGNED <i>20 Dec 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		22d. ADDRESS <i>Cockeysville Snd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12, 22, 66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Jessops</i>		23d. LOCATION (City, town or county) (State) <i>Cockeysville, Balto, Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. Cook-Brooks Towson</i>		24. ADDRESS <i>Towson, Md. 21204</i>	
25a. REC'D BY REGISTRAR <i>DEC 23 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

16885

CERTIFICATE OF DEATH

16884

I, John Taylor, of the County of Jefferson, State of Mississippi, do hereby certify that on the 12th day of April, 1912, at Jefferson, Mississippi, died John Taylor, of the County of Jefferson, State of Mississippi, who was born on the 12th day of April, 1872, at Jefferson, Mississippi, and was a resident of Jefferson, Mississippi, at the time of his death.

Witness my hand and the seal of said County, at Jefferson, Mississippi, this 12th day of April, 1912.

John Taylor  
 County Clerk

Subscribed and sworn to before me this 12th day of April, 1912.  
 Notary Public for Mississippi  
 My Comm. expires 1st day of April, 1913.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16886

## CERTIFICATE OF DEATH

16885

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Wilburn</b> Last <b>Thiemo</b>				4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>19 66</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1907</b>		9. AGE (In years last birthday) <b>59</b> yrs.	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>00</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Jack E. Wilburn</b>				14. MOTHER'S MAIDEN NAME <b>Mary Crawford</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 7, 1966</b> to <b>Dec. 16, 1966</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Dec. 16, 1966</b> , and that death occurred at <b>11:00</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12-20-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>			22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Ch. Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air Md</b>	
24. FUNERAL DIRECTOR <i>Atulchins Funeral Home Owings, Md</i>			ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
16887 CERTIFICATE OF DEATH 16886

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Albert</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-11-06</u> 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA - U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Thomas</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA JONES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>212-09-0149</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sq. Ca of tonsils</u> DUE TO (b) <u>Metast Ca in Lungs</u> DUE TO (c) <u>Emaciation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from <u>Aug 25</u> , 19 <u>66</u> to <u>Dec. 24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24</u> , 19 <u>66</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>a. Taheri</u>		22b. DATE SIGNED <u>Dec. 26 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Amanollah Taheri</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEM. MELROSE METHODIST CHURCH</u>	23d. LOCATION (City, town or county) (State) <u>LOTSBURG, VA.</u>
24. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u>		25a. REC'D BY REGISTRAR <u>DEC 30 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



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*[Faint, illegible handwriting]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>16888</b> 1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			Item 12 Film 6384 1/6/67 mh <b>16887</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>app. 10 yrs</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			<b>03.1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>718 Eastshire Drive</b>						d. STREET ADDRESS <b>718 Eastshire Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>CORINNA</b>			<b>First Middle Last</b> <b>TOGNOCCHI</b>			4. DATE OF DEATH <b>December 26 1966</b>			<b>Month Day Year</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Dec. 26, 1886</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Pietro Pezzica</b>						14. MOTHER'S MAIDEN NAME <b>Ida Boni</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT <b>Mrs Brung Lewis</b>			Address <b>718 Eastshire Dr</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Acute Coronary Insufficiency</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardio Vasc Disease</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 23, 1966</b> , to <b>Dec 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>Dec 23, 1966</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>J. Wilson McKay</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>12-28-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>J. Wilson McKay</b>						22d. ADDRESS <b>236 Edmondson</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Dec. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemt</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>STERLING FUNERAL ESTATE</b>						25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

10881

ALPHABET OF A-Z

10882

CERTIFICATE OF DEATH

16889

16888

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Cockeysville 21030</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, 7620 York Rd. 21204</b>		d. STREET ADDRESS <b>10304 Malcolm Circle</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>M.</b> Last <b>TRAGESER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-4-84 85</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Trageser</b>		14. MOTHER'S MAIDEN NAME <b>Margaret A. Petrie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-1375</b>	
17. INFORMANT <b>Niece: Mrs. Claire Sanders same as pt.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Failure</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>12-14-</b> , <b>19 66</b> , to <b>12-27</b> , <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>12-27-</b> , <b>19 66</b> , and that death occurred at <b>4:35</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Joel V. Tolentino</b>		22b. DATE SIGNED <b>12/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joel V. Tolentino</b>		22d. ADDRESS <b>St. Joseph Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL, or other disposition	23b. DATE THEREOF <b>12/30/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 28 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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George Washington

St. George's Hospital, 7000 York St. London

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MDARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16889

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>6 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Res., 1716 Evergreen Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>1716 Evergreen Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GUY</b> Middle <b>J.</b> Last <b>TRENTON, JR.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12-1919</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bethlehem Steel Co.</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Guy J. Trenton Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Ruth Stonebreaker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes, Army</b>	
16. SOCIAL SECURITY NO. <b>236-20-9451</b>		17. INFORMANT <b>Wife, Beatrice Trenton, # 2, a, b, c, d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound of trunk</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>981X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Baltimore</b> (County) (State)
21. I certify that I took charge of the remains described above, held <u>an Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <u>Homicide</u> <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>December 23, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 27-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		23d. LOCATION (City or Town) <b>Baltimore, Maryland 21228</b> (County) (State)	
25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16891

CERTIFICATE OF DEATH

16890

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>9101 SIMMS AVENUE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANK ELWOOD TRIMBLE JR.</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 10 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 8, 1923</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE GUNNER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK E. TRIMBLE SR.</b>		14. MOTHER'S MAIDEN NAME <b>Emma S. Price.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>215 14 09 35</b>	
17. INFORMANT <b>VA HOSPITAL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EXTREME CACHEXIA AND ANEMIA</b> DUE TO (c) <b>CARCINOMA OF BLADDER WITH METASTASES</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE DECUBITIS ULCERS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>UNKNOWN</b> <b>20 MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>DEC 8</b> , 19 <b>66</b> , to <b>DEC 10</b> , 1966, that (a) (we) last saw the deceased alive on <b>DEC 10</b> , 19 <b>66</b> , and that death occurred at <b>115A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Pushpendra Senan</b>		22b. DATE SIGNED <b>12/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>PUSHPENDRA SENAN</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>LEONARD J. RUCK FUN. HOME</b>		25a. REC'D BY REGISTRAR <b>DEC 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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ALL INFORMATION

ALL INFORMATION

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 10450 JAW/STW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>26 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> <u>03.1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>219 Melancthon Avenue</u>						d. STREET ADDRESS <u>219 Melancthon Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First <u>O</u> Middle <u>Trussell</u> Last						4. DATE OF DEATH <u>December</u> Month <u>3</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 Sept. 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael C. O'Brien</u>						14. MOTHER'S MAIDEN NAME <u>Mary</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Lillian Horner-Belfast Rd.-Sparks</u> Address <u>Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>66</u> to <u>December</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3 December 1966</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Walter J. Kees</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3 Dec 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER J. KEES</u>						22d. ADDRESS <u>Cooneyville, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>		
24. FUNERAL DIRECTOR <u>HENRY SANDER &amp; SONS INC BALTIMORE MD.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

BP

10831

10831



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 04-03-00 BY 10831

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

16893

16892

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>18 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNA POLIS</b> d. STREET ADDRESS <b>TYLER AVE &amp; FOREST DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) <b>CLIFFORD WILLIAM TYLER</b>		<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>12</b> Year <b>1966</b>		<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDDED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>5/10/10</b>		<b>9. AGE (In years last birthday)</b> <b>56</b> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																				
Months	Days																				
	Hours																				
	Min.																				
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>PAINTER</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>PAINTING</b>				<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>											
<b>13. FATHER'S NAME</b> <b>GEORGE N. TYLER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA MAE MILTON</b>																	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>214-14-8996</b>				<b>17. INFORMANT</b> <b>Records, Mt. Wilson State Hospital</b>													
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> (b) <b>Cor pulmonale</b> (c) <b>Pulmonary Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b> <b>5 years</b> <b>15 years</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>													
<b>21. I certify that (this hospital) attended the deceased from 12/7, 1966, to 12/8, 1966, that (he) last saw the deceased alive on 12/8, 1966, and that death occurred at 7 A.M. from the causes and on the date stated above.</b>																					
<b>22a. SIGNATURE</b> <b>Wm. Newcomer</b>										<b>22b. DATE SIGNED</b> <b>12/8/66</b>											
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Wm. Newcomer, M.D., Superintendent</b>										<b>22d. ADDRESS</b> <b>Mount Wilson, Maryland</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>12-12-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Marys</b>		<b>23d. LOCATION (City, town, or county) (State)</b> <b>ANNA POLIS MD.</b>													
<b>24. FUNERAL DIRECTOR</b> <b>John M. Taylor</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DEC 13 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		<b>25c. ADDRESS</b> <b>Annapolis, Md.</b>													

1083

1083

San Joaquin County

Mount Wilson

Mount Wilson State Hospital

Mount Wilson State Hospital

Mount Wilson, Maryland



CERTIFICATE OF DEATH

16894

16893

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>30-4</b>	
4. NAME OF DECEASED OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d. STREET ADDRESS <b>6119 Parkway Dr. 21212</b>	
5. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>S.</b> Last <b>Varney</b>		4. DATE OF DEATH Month <b>December</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/43</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Va. Paper Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sumner O. Varney</b>		14. MOTHER'S MAIDEN NAME <b>Marian Hill</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-42-0743</b>	
17. INFORMANT <b>Mrs. Kathleen Varney</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxic Cardiac Arrest</b> DUE TO <b>572.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration of Gastric Contents</b> (c) <b>Vomiting sec. to Chronic ulcerative colitis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Sudden</b> <b>11 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 23, 1966</b> , to <b>December 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 26, 1966</b> , and that death occurred at <b>11:29</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>12/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Rd. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE THEREOF <b>12/29/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 27 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

16895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16894

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 Sandsbury Road</b>				d. STREET ADDRESS <b>10 Sandsbury Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>JOSEPH</b> Last <b>VOGEL</b>				4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1907</b>		9. AGE (In years lost birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George P. Vogel</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Suresch</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-8716</b>		17. INFORMANT Address <b>Mrs. Margaret B. Vogel (Same)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>		EXAMINER'S NAME (Type) <b>Charles S. Petty</b>				22. DATE SIGNED <b>12/8/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Grds. Timonium, Balto. Co., Md.</b>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10/30

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16896

## CERTIFICATE OF DEATH

16895

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2 Maple Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> d. STREET ADDRESS <u>2 Maple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MINNA</u> Middle <u>C.</u> Last <u>VON SCHRADER</u>				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>9</u> Year <u>19 66</u>													
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 1, 1894</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>      </u> Days <u>      </u>		<b>IF UNDER 24 HRS.</b> Hours <u>      </u> Min. <u>      </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At home</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A?</u>					
<b>13. FATHER'S NAME</b> <u>John Kastner</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Caroline Kleinhein</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b>  						<b>17. INFORMANT</b> Address <u>Henry Von Schrader 2 Maple Ave. 21206</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Disease</u> <u>4/22/2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>43 yrs</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>      </u> p.m. <u>      </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  		<b>20f. (City or town)</b> (County) (State)  									
<b>21. I certify that (I) (this hospital) attended the deceased from <u>12-15</u>, 19<u>66</u> to <u>11-29</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>11-29</u>, 19<u>66</u>, and that death occurred at <u>6 AM</u> from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Milton C. Lang</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>12-10-66</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Milton C. Lang, M.D.</u>						<b>22d. ADDRESS</b> <u>2117 Belair Road</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/12/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery,</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Woodlawn, Md.</u>							
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ullrich Funeral Home</u>						<b>ADDRESS</b> <u>4210 Belair Road.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>DEC 15 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Bureau of Plant Industry" and "Washington, D. C." are faintly visible.]*

*[Faint, mostly illegible text on the right margin, likely bleed-through from the reverse side of the page.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

16897

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16896

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>03-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>300 POPLAR RD.</b>		d. STREET ADDRESS <b>300 POPLAR RD.</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN JOSEPH WALDHAUSER</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 6 1908</b>
9. AGE (In years lost birthday) yrs. <b>58</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>8</b> Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RACE OFF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN WALDHAUSER</b>		14. MOTHER'S MAIDEN NAME <b>CLARA FUNK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>217-22-7928</b>	
17. INFORMANT <b>WIFE</b>		Address <b>Selomia Waldhauser, 300 Poplar Rd ABOVE Essex, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>acute Coronary Occlusion</b> DUE TO <b>HCND</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C. Patterson</b> M.D. EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>		22. DATE SIGNED <b>12/3/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/6/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BEL-AIR MEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BELAIR MD</b>	
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
ADDRESS <b>300 MACE</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16898

CERTIFICATE OF DEATH

16897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> 0311			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1124 Elmridge Avenue</b>				d. STREET ADDRESS <b>1124 Elmridge Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD VERNON WARRINGTON</b>				4. DATE OF DEATH Month Day Year <b>December 29, 1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-9-1912</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Warrington</b>				14. MOTHER'S MAIDEN NAME <b>Lilly Newbert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W W II</b>		16. SOCIAL SECURITY NO. <b>215-10-0516</b>		17. INFORMANT Address <b>Mrs. Gladys M. Warrington, 1124 Elmridge Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardiovascular Disease</b> <b>420.1</b> DUE TO <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO <b>Abnormal Pericardial Effusion</b> (c) <b>Rel. Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4y.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/31, 1966</b> to <b>12/29, 1966</b> that (I) (we) last saw the deceased alive on <b>12/27, 1966</b> and that death occurred at <b>4:30 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>E. Kasaitis</b>				22b. DATE SIGNED <b>12/29/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. E. Kasaitis</b>	
22d. ADDRESS <b>1801 Frederick Road, Balto., Md. 21228</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16899

## CERTIFICATE OF DEATH

16898

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Towson</b>		c. LENGTH OF STAY IN 1b <b>03.1</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>		d. STREET ADDRESS <b>802 Register Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1301 Dulaney Valley Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Avery</b> Middle <b>Dyer</b> Last <b>Webster</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1897</b>
9. AGE (In years lost birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tide Water Oil</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Haven, Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hanford Webster</b>		14. MOTHER'S MAIDEN NAME <b>Dora Kent</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-8125A</b>	
17. INFORMANT <b>Mrs. Ellenor G. Webster-802 Register Ave.</b>		Address <b>21212</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1</b> , 19 <b>66</b> , to <b>Dec. 25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Dec. 25</b> , 19 <b>66</b> , and that death occurred at <b>5:17</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Lawrence Post</b>		22b. DATE SIGNED <b>12/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Lawrence Post</b>		22d. ADDRESS <b>York Rd. &amp; n Pot Spring Rd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville 8, Md.</b>	
24. FUNERAL DIRECTOR <b>Loring Byers-9728 Liberty Rd. Randallstown, Md.</b>		25. REC'D BY REGISTRAR <b>DEC 28 1966</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
16800					16899					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <b>Baltimore</b>					a. STATE <b>Md.</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					b. COUNTY <b>—</b>					
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
<b>1833 Wycliff Rd., # 21234</b>					<b>3308 Foster Ave., # 21224.</b>					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
<b>MARGARET WEHNER</b>					<b>December 20, 1966</b>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
<b>Female</b>		<b>White</b>		<b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>Oct. 16, 1874</b>		<b>92</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
<b>Retired</b>			<b>House Work</b>			<b>Baltimore, Md.</b>			<b>U.S.A.</b>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
<b>Matthew Riedel</b>					<b>Wilhelmina ?</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address	
<b>No</b>			<b>None</b>			<b>Edward Wehner</b>			<b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension, Ruptured Aorta</b>										
443X DUE TO <b>Chronic &amp; Myo cardiac failure.</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)	
Hour a.m. p.m. 19			While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1964</b> , to <b>12/20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> , 19 <b>66</b> , and that death occurred at <b>10:30 A.M.</b> on the date stated above.										
22a. SIGNATURE <b>Joseph R. Liberto</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>12/24/66</b>
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH R. LIBERTO</b>					22d. ADDRESS <b>3508 Bland St. - Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)	
<b>Burial</b>			<b>12-23-66</b>			<b>Sacred Heart Cemetery</b>			<b>7401 German Hill Rd., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geller</b>					25a. REC'D BY REGISTRAR <b>DEC 27 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

16901

16900

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> c. LENGTH OF STAY IN 1b <b>16 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7514 Old Battle Grove Road</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> d. STREET ADDRESS <b>7514 Old Battle Grove Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marion R. Welzel</b>		4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/18/24</b>
9. AGE (In years last birthday) <b>42 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William A. Heflin</b>		14. MOTHER'S MAIDEN NAME <b>Sylvia Burns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-16-4056</b>	
17. INFORMANT (Husband) <b>Charles Welzel, 7514 Old Battle Grove Rd.</b>		Address <b>Dundalk, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH ABDOMINAL METASTASES</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> , 19 <b>66</b> , to <b>12-1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12-1</b> 19 <b>66</b> , and that death occurred at <b>7<sup>20</sup></b> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <b>A. A. Alecce</b>		22b. DATE SIGNED <b>12/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. A. Alecce M. D.</b>		22d. ADDRESS <b>1123 St. Paul St. Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>	
ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner of the State along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16902

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18052

1. PLACE OF DEATH a. COUNTY <i>Balt.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Wilson Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg.</i> 10.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Mt. Wilson State Hosp.</i>		d. STREET ADDRESS <i>Rt. 1</i>	
3. NAME OF DECEASED (Type or print) <i>NORMAN HENRY WETZEL</i>		4. DATE OF DEATH <i>Dec 19 1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-11-88</i>
9. AGE (In years lost birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John Wetzel</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Ferguson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no none</i>		16. SOCIAL SECURITY NO. <i>220 18 1919</i>	
17. INFORMANT <i>Mt. Wilson Hosp. Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pulmonary Thc. (active)</i> DUE TO (b) <i>102.1</i> DUE TO (c) <i>Fractured Rt. Hip.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fractured Rt. Hip.</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fell going to bath room</i>	
20c. TIME OF INJURY Month, Day, Year <i>11:30 p.m. 8-26 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <i>Hospital</i>		20f. (City or town) (County) (State) <i>Mt. Wilson Balt. Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <i>12-19-66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Dec. 20, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>New Calhoun Cemetery Baltimore Md.</i>		23d. LOCATION (City or town) (County) (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Frank H. Newell, Baltimore Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13081

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

16903

16901

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>18 Jones Ave.</b>				d. STREET ADDRESS <b>18 Jones Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Wilbur Whitaker</b>				4. DATE OF DEATH Month <b>12</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1911</b>	9. AGE (In years last birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNK.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Jonestown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Whitaker</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNK.</b>		17. INFORMANT <b>John Stewart</b>		Address <b>18 Jones Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno Carcinoma Mediastinum</b> <b>164X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>primary site unknown</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH <b>one year.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b></b> e.m. <b></b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1965</b> to <b>12/2/66</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>11/30/66</b> , and that death occurred <b>9:00 AM</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>W E McGrath</b>				22b. DATE SIGNED <b>12/2/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>W E McGrath</b>				22d. ADDRESS <b>1303 Frederick Rd Catonsville</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>		23d. LOCATION (City, town or county) (State) <b>A.A. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>MORTON + Dye II</b>				ADDRESS <b>1701 LAURENS</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 7 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

19031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16904

CERTIFICATE OF DEATH

16902

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>26 Days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>316 N. Mount Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD (NMI) WHITE</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 5TH 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9/1/89</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Island Creek, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William White</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Robinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>218-12-73-40</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>GANGRENE RIGHT LEG WITH ABOVE KNEE AMPUTATION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>11/9/66</b> to <b>12/5/66</b> , that (2) (we) last saw the deceased alive on <b>12/5/66</b> , and that death occurred at <b>1:20 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Milton Ginsberg</b>		22b. DATE SIGNED <b>12/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Hayes Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



13304

13304

ARTERIOCLASTIC HEART DISEASE

TABERNER HIGHT 123 WEST ABBOT STREET AMSTERDAM

VAL TONY HOWARD, FARMER

ELTON GIBBINS, M. D.

12/10/1942  
Marking 8 pages



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
16905						16903					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			BALTO			a. STATE			MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			PARKVILLE			b. COUNTY			BALTO		
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
3206 WOODSIDE AVE						3206 WOODSIDE AVE					
e. IS RESIDENCE ON A FARM?						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
ELLA			V WICK			DEC 11			1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT 31 1883		83 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
at home								Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JAMES D FERGUSON						MARY WRIGHTSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
NO						Family Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
422.1 Cerebral Vascular Accident (Thrombosis) 1/2 hr											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
Anteriosclerotic Cardio Vascular Disease 20 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (the hospital) attended the deceased from Sept 1959, to 25 Nov 1966, that (I) (we) last saw the deceased alive on 25 Nov 1966, and that death occurred at 8:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE						M.D. ATTENDING PHYS.			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type)						22b. DATE SIGNED			22d. ADDRESS		
Dr. Thomas J. Brennan						13 Dec 1966			5217 HARFORD RD. BALTO MD 21214		
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial				12-14-66		Oaklawn Cem.		BALTO MD			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
C. F. EVANS & SON 8802 HARFORD RD						DEC 19 1966			Charles Judge		

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10000



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16906

## CERTIFICATE OF DEATH

16904

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK (21222) 031</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>209 PATAPSCO AVE.</b>				d. STREET ADDRESS <b>209 PATAPSCO AVE</b>			
3. NAME OF DECEASED (Type or print) <b>CLARA ELIZABETH PERKINS WILLEY</b>				4. DATE OF DEATH <b>DEC. 7 1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/29/1914</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W.M. T. PERKINS</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH ROBERTS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>ROBERT M. WILLEY, (SEE 2 ABOVE)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA of the STOMACH INVASIVE</b> <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>NOV</b> , 1966, to <b>Dec 7</b> , 1966, that (I) (we) last saw the deceased alive on <b>NOV 19 66</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen C. Mackowiak</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-9-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>S.C. MACKOWIAK</b>				22d. ADDRESS <b>6714 HORA BIRDAU</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ONE LAWN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>BALTO. CO. MD</b>	
24. FUNERAL DIRECTOR <b>W. Brooks Bradley, Dundalk, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

5021

1005

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)  
6M 1/66

FOR STATE  
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16907

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16905

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bengies Road (Box 3000)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DEWIGHT DUCKERT</b> First <b>E.</b> Middle <b>WILLIAMS</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1966</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Orville E. Williams, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sandra Gilbert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Orville E. Williams, Jr., Bradshaw, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Body Burns and Carbon Monoxide Intoxication.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>916.0</b> (c) <b>Intoxication.</b> DUE TO (a) <b>Intoxication.</b> (b) <b>Intoxication.</b> (c) <b>Intoxication.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Conflagration of home.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12/13/ 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Essex Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>12/13/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		23d. LOCATION (City or Town) (County) (State) <b>MAGNOLIA HANFORD MD</b>	
24. FUNERAL DIRECTOR <b>George W. TITTLE BELAIR MD</b>		25a. REC'D BY REGISTRAR <b>DEC 22 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16908

CERTIFICATE OF DEATH

16906

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>46 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2571 W. Baltimore Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>E.</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>20</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9/9/06</b>
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEVEDORE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARY HILL, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD E WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>JANE DOUGLAS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>184 01 26 93</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>ULCER OF LEFT ANKLE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL THROMBOSIS, CLINICAL</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>11/4/66</b> , 19____, to <b>12/20/66</b> , 19____, that (we) last saw the deceased alive on <b>12/20/66</b> , 19____, and that death occurred at <b>2:05 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED <b>12/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-23-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <i>Chas O. Wilson</i>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



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RECEIVED AT DEATH

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16909

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16907

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>3202 Ryan Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Elsie Pauline Wilson</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-11-18</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>16</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Ruby Robey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Sept. 14</b> , 19 <b>66</b> , to <b>Dec. 25</b> , 19 <b>66</b> , that (2) (we) last saw the deceased alive on <b>December 25</b> , 19 <b>66</b> , and that death occurred at <b>5 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A Taheri</b>		22b. DATE SIGNED <b>12-26-66</b>	
22c. PHYSICIAN'S NAME (Typed) <b>Manollah Taheri</b>		22d. ADDRESS <b>Spring Grove State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 28-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros</b>		25a. REC'D BY REGISTRAR <b>DEC 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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<div> <div>16910</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div>16908</div> </div>																																			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6547 BALTIMORE AVE</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> d. STREET ADDRESS <u>6547 BALTIMORE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARION LOUISE WILSON</u>			<b>4. DATE OF DEATH</b> <u>DEC 2 1966</u>			<b>5. SEX</b> <u>FEMALE</u>			<b>6. COLOR OR RACE</b> <u>WHITE</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>FEB 14, 1932</u>			<b>9. AGE</b> (In years last birthday) <u>34</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.																	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b>						<b>11. BIRTHPLACE</b> (State or foreign country) <u>NEW YORK</u>						<b>12. CITIZEN OF WHAT COUNTRY?</b>																	
<b>13. FATHER'S NAME</b> <u>ELMER KIRKUM</u>												<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>																							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)												<b>16. SOCIAL SECURITY NO.</b>												<b>17. INFORMANT</b> <u>ELMER C. WILSON 6547 BALTIMORE AV</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Peroral Failure</u> <u>260X</u> DUE TO (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)																		<b>INTERVAL BETWEEN ONSET AND DEATH</b>																	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Multiple myeloma</u>																		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b>																		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>																							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
<b>ACTUAL SIGNATURE</b> <u>Theodore C. Patterson</u> M.D.																		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>12/3/66</u>											
<b>EXAMINER'S NAME</b> (Type) <u>THEODORE C. PATTERSON</u>																		<b>Address</b> (Street, city, town, or county) <u>105 MAIN ST</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>DEC 5, 1966</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GARDENS OF FAITH</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>OVERLEA MD</u>																							
<b>23. FUNERAL DIRECTOR</b> <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>												<b>24a. REC'D BY REGISTRAR</b> <u>DEC 5 1966</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>																					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

16911

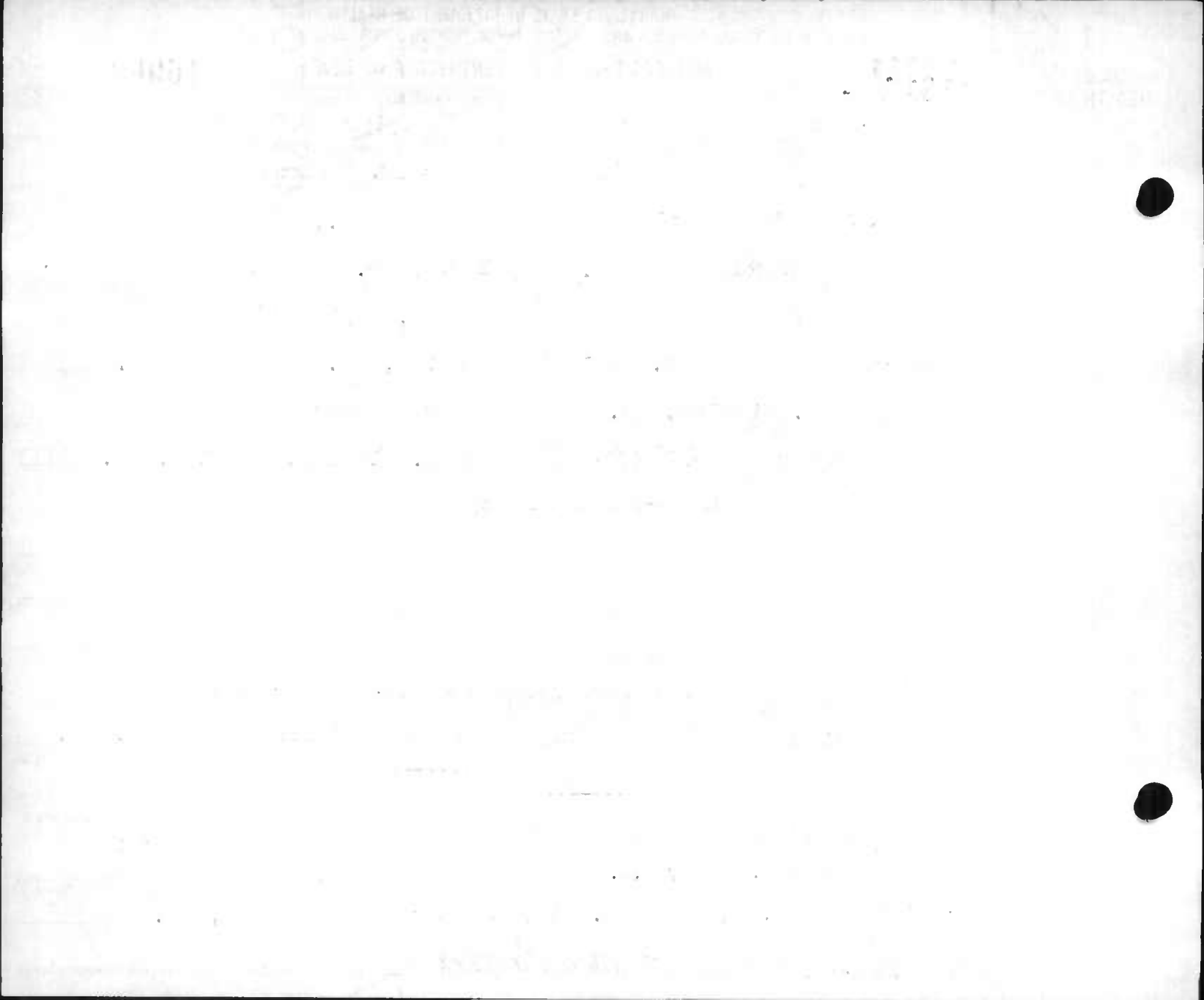
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16909

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN lb <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>York Rd.,</b>			
3. NAME OF DECEASED (Type or print) First <b>WINFRED</b> Middle <b>H.</b> Last <b>WINGLER, Jr.</b>				4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1931</b>	9. AGE (In years lost birthday) yrs. <b>35</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Pub. Utilities</b>		11. BIRTHPLACE (State or foreign country) <b>Marion, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>Winfred H. Wingler, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Debord</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Korean</b>			16. SOCIAL SECURITY NO. <b>215-28-3197</b>	17. INFORMANT <b>Vernon L. Wingler, Monkton, Md. 21111</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio-cerebral Injury</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident - Deceased was a Driver</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12 18</b> p.m. <b>19 66</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		
			20f. (City or town) <b>Parkton</b>		(County) <b>Balto.</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>				22. DATE SIGNED <b>12/20/66</b>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 22, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Freeland, Md.</b>	
24. FUNERAL DIRECTOR <b>Isaac Hartenstein, New Freedom, Pa. 17348</b>				25a. REC'D BY REGISTRAR <b>DEC 21 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16910

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Hospital</b>		d. STREET ADDRESS <b>5429 Rummel Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>James Stanley Wisniewski Sr.</b>		4. DATE OF DEATH <b>12</b> Month <b>23</b> Day <b>1966</b> Year	
5. SEX <b>Male</b>	8. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-1-1930</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>STANISLAUS WISNIEWSKI</b>		14. MOTHER'S MAIDEN NAME <b>MARY BIELATOWICZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-26-1831</b>	
17. INFORMANT <b>WIFE</b> <b>MRS. RUTH E. WISNIEWSKI</b>		Address <b>(SAME)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture, Skull, Compound, Anterior</b> <b>8234</b> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture, Mandible</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Struck utility pole with automobile</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:30</b> Hour <b>2</b> p.m. <b>12-23</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Sparrows Pt. Balt.</b>		20f. (City or town) (County) (State) <b>Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>M. Davis</i>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>Melvin B. DAVIS M.D., 6800 Mornington Rd., Dundalk, Maryland</b>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-28-1966</b>	
23c. NAME OF CEMETERY OR INTERMENTARY <b>BALTO. NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>5501 FREDERICK RD. BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>J. Walter Conklin</b>		ADDRESS <b>5444 BELAIR RD.</b>	
25a. REC'D BY REGISTRAR <b>DEC 28 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16913

CERTIFICATE OF DEATH

16911

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Towson</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Villa Maria, Notch Cliff</b>			d. STREET ADDRESS <b>Glenarm, Road, Glenarm, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sr. Mary Leonadis Wohlfort</b>			4. DATE OF DEATH Month Day Year <b>12 2 19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 - 9 - 1881</b>	9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		1Db. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Austria</b>	
13. FATHER'S NAME <b>John Wohlfort</b>			14. MOTHER'S MAIDEN NAME <b>Marie Webber</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-54-2673</b>		17. INFORMANT <b>Sr. M. Kathleen</b> Address <b>Glenarm, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Diabetes Mellitus</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 19</b> , 19 <b>66</b> , to <b>November 20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>November 20</b> , 19 <b>66</b> , and that death occurred at <b>12:15 p.m.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Henry L. McCorkle</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY L. MCCORKLE MD</b>		22d. ADDRESS <b>Phoenix Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>DEC. 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SISTERS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>GLEN ARM BALTIMORE, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>RAYMOND V. CURRAN</b>		ADDRESS <b>817 SCARLETT DR TOWSON, MD. 21204</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>

1831

STATE OF OHIO

1831

Name of the person		Age		Sex		Color		Rank		Profession		Religion		Marital Status		Place of Birth		Date of Arrival		Date of Departure		Remarks	
John A. Brown		25		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Mary A. Brown		22		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
James A. Brown		20		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Elizabeth A. Brown		18		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
William A. Brown		15		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Sarah A. Brown		12		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Thomas A. Brown		10		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Ann A. Brown		8		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Robert A. Brown		6		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Margaret A. Brown		4		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Charles A. Brown		3		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
Elizabeth A. Brown		2		Female		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	
John A. Brown		1		Male		White		Private		Soldier		Protestant		Single		Ohio		1830		1831		Faint handwriting	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G384 12/22/66 mh

16914

CERTIFICATE OF DEATH

16912

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN TB <b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1100E. Belvedere Ave. #21212</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE A WOLF</b>		4. DATE OF DEATH Month <b>12-</b> Day <b>11</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-14-86</b>
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILIP WOLF</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DRESSEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>1212-01-1234</b>		16. SOCIAL SECURITY NO. <b>420-1</b>	
17. INFORMANT <b>Wife - Alice C. Wolf</b>		Address <b>same as patient</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> DUE TO (b) <b>Thrombosis right coronary artery</b> DUE TO (c) <b>Atherosclerosis, generalized, severe</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia - Cerebral Infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>10-27</b> , 19 <b>66</b> to <b>12-11</b> , 19 <b>66</b> , that (he) (we) last saw the deceased alive on <b>12-11</b> , 19 <b>66</b> , and that death occurred at <b>8:30 A</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Manuel S. Cockburn</b>		22b. DATE SIGNED <b>12-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Manuel S. Cockburn, M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/14/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cury</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore</b>	
24. FUNERAL DIRECTOR <b>P.A. Heeman</b>		25a. REC'D BY REGISTRAR <b>6067 HARTFORD Rd</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 16 1966</b>	

1931

CERTIFICATE OF DEATH

1931

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16915

CERTIFICATE OF DEATH

16913

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21236</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Josephs Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Myrtle</b> Middle <b>M.</b> Last <b>WOLLSCHLAGER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1896</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter L. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Louise Heighs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-22-3711 A</b>	
17. INFORMANT <b>Mr. Stanley Wollschlager</b>		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>December 19, 1966</b> to <b>December 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>December 30, 1966</b> , and that death occurred at <b>4:20a</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Joel V. Tolentino</i>		22b. DATE SIGNED <b>Dec. 30, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joel V. Tolentino M.D.</b>		22d. ADDRESS <b>7620 York Rd. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/3/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>	25b. REGISTRAR'S SIGNATURE <i>James Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1931

CERTIFICATE OF DEATH

1931

Name of Deceased		Date of Death	
John Doe		Jan 1, 1931	
Age		Sex	
65		Male	
Cause of Death		Place of Death	
Heart Disease		Home	
Time of Death		Signature of Physician	
10:30 AM		[Signature]	
Witnesses		Signature of Registrar	
[Signatures]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16916

CERTIFICATE OF DEATH

16914

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>55 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1040 N. Calvert Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER Brown WOODYARD</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 8 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1895</b> <b>JUNE 12, 1894</b>	
9. AGE (In years last birthday) <b>72 7/8</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARINE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PIKE COUNTY, KENTUCKY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WALTER C. WOODYARD</b>			
14. MOTHER'S MAIDEN NAME <b>LENORA WEDDINGTON</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>			
16. SOCIAL SECURITY NO. <b>132 03 24 74</b>				17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>PULMONARY EDEMA</b> <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>PULMONARY EMPHYSEMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT OLD OLD</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ENCEPHALOMALACIA, OLD SURGICAL ABSENCE RIGHT LEG, OLD</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>10/14/66</b> , to <b>12/8/66</b> , 19__, the (we) last saw the deceased alive on <b>12/8/66</b> , 19__, and that death occurred at <b>11:20A</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>Kurt Raab</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>KURT RAAB, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Dec. 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>Wm. Cook-Brooks Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

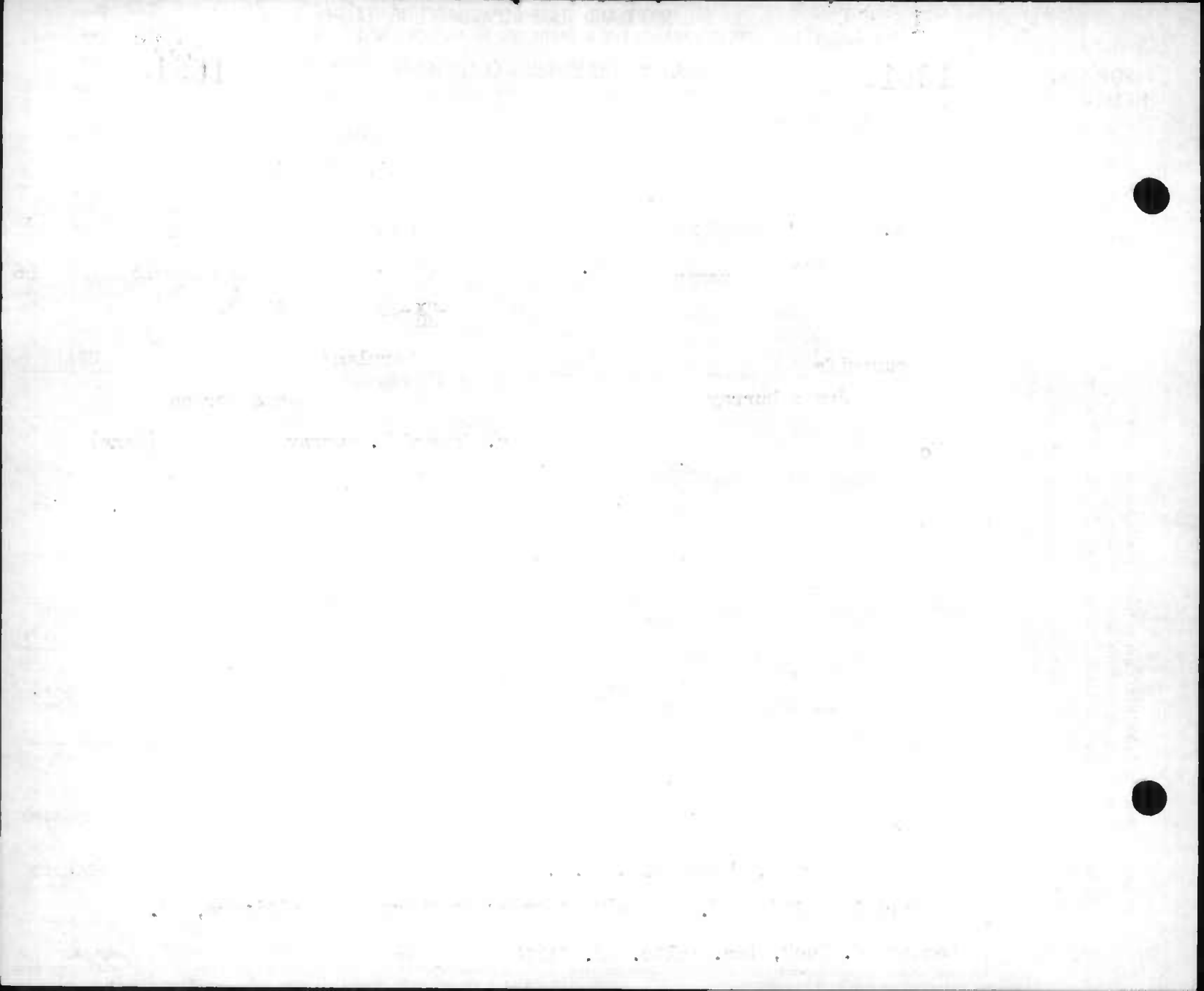
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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>Baltimore #6</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph 'S Hospital</b>		d. STREET ADDRESS <b>4404 Cook Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Anne Annie E. WORTMAN</b>		4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-82</b>
9. AGE (In years last birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Murray</b>		14. MOTHER'S MAIDEN NAME <b>Anne Gordon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Howard R. Murray</b>		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X Multiple fractures of skull from cerebral hemorrhage</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12/16/66</b> <b>10 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down at foot of stairs after cerebral hemorrhage</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8</b> p.m. <b>12/16/66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>12/16/66</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/20/66.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>DEC 19 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**16918**

**CERTIFICATE OF DEATH**

**16916**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. <b>PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5715 Edmondson Ave.</b>		2. <b>USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto Co</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>5715 Edmondson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. <b>NAME OF DECEASED</b> (Type or print) <b>Richard E. Wunder</b> First Middle Last		4. <b>DATE OF DEATH</b> <b>Dec. 27</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-3-97</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Wunder Coffee</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Joseph Wunder</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO.	
17. <b>INFORMANT</b> <b>Mrs. Richard E. Wunder</b> <b>5715 Edmondson Ave.</b>		Address	
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 severe pulmonary emphysema</b> DUE TO (b) <b>arteriosclerotic Cardio Vascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 7, 1957</b> to <b>Dec 27, 1966</b> , that (I) (we) saw the deceased alive on <b>Dec 27, 1966</b> , and that death occurred at <b>7:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Harry L. Knipp</b>		22b. DATE SIGNED <b>12-29-66</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>Harry L. Knipp, M.D.</b>		22d. ADDRESS <b>4116 Edmondson Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-30-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>DEC 30 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

clear

21232



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16919

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

16917

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b> 03.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>607 Almond Ave.</b>				d. STREET ADDRESS <b>607 Almond Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH Yeager</b>				4. DATE OF DEATH <b>Nov 30 - 66.</b>			
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 19 - 1906</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS HALL</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MORRIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>M<sup>rs</sup> Yeager (son)</b> Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Carcinoma of Stomach -</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>N/A</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>M. Davis</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>5-12-67</b>	
EXAMINER'S NAME (Type) <b>MELVIN DAVIS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-3-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak-Lawn Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Md.</b>	
24. FUNERAL DIRECTOR <b>John G. Connelly Sons - 300 Mac (21)</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>John G. Connelly</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Glyndon</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>(Melinda) Worthington Ave.</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Glyndon</b> d. STREET ADDRESS <b>(Melinda) Worthington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Albert</b> Middle <b>R.</b> Last <b>Zimmerman</b>					<b>4. DATE OF DEATH</b> Month <b>Dec.</b> Day <b>5</b> Year <b>1966</b>				
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 11, 1882</b>		<b>9. AGE</b> (In years last birthday) <b>84</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>3</b> Hours <b>1</b> IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Owner</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Wholesale Produce</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>William E. Zimmerman</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Steele</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>215-24-8953A</b>		<b>17. INFORMANT</b> <b>Mrs. Gertrude H. Zimmerman</b>			<b>Address</b> <b>(Same)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of aortic aneurysm</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr.</b> <b>years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <b>(IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1948, to Dec. 3, 1966, that (I) (we) last saw the deceased alive on Dec. 3, 1966, and that death occurred at 3:15 p.m. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Martin E. Strobel</b>					<b>22b. DATE SIGNED</b> <b>12-5-66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Martin E. Strobel, M.D.</b>		
<b>22d. ADDRESS</b> <b>48 Main St. Reisterstown, Md.</b>					<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>12/9/66.</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Baltimore, Md.</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>					<b>25a. REC'D BY REGISTRAR</b> <b>DATE DEC 7 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16921

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16919

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn 03.1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1640 Ingleside Ave		d. STREET ADDRESS 1640 Ingleside Ave.		
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Marion Zimmerman.		4. DATE OF DEATH Month Day Year Dec. 15, 1966		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1894	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Business		11. BIRTHPLACE (County & State, or foreign country) Md.		
13. FATHER'S NAME Franklin M. Zimmerman		14. MOTHER'S MAIDEN NAME Ella C. Williams		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W.W.I		16. SOCIAL SECURITY NO. 418-32-2426		
17. INFORMANT Mrs. Helen W. Zimmerman		Address 1640 Ingleside		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary artery occlusion 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign Hypertension DUE TO (c) arteriosclerotic Cardio-Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 16, 1960, to Dec 15, 1966, that (I) (we) last saw the deceased alive on Dec 28, 1965, and that death occurred at 4:10 P.M. from the causes and on the date stated above.				
22a. SIGNATURE Harry L. Knipp		22b. DATE SIGNED 12-16-66		
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.		22d. ADDRESS 4116 Edmondson Ave., 21229		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-1966		
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn Md.		
24. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.		25a. REC'D BY REGISTRAR DEC 19 1966		
		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16922

CERTIFICATE OF DEATH

16920

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1752 Yakona Road</b>		d. STREET ADDRESS <b>1752 Yakona Road</b>	
3. NAME OF DECEASED (Type or print) <b>FRANKLIN MILTON ZOELLER</b>		4. DATE OF DEATH <b>December 7, 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1926</b>
9. AGE (In years last birthday) <b>40</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tool</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Zoeller</b>		14. MOTHER'S MAIDEN NAME <b>Verona A. Titus</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>Juanita K. Zoeller</b>		Address <b>1752 Yakona Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 7, 1965</b> to <b>Dec 7, 1966</b> that (I) (we) last saw the deceased alive on <b>Dec 6, 1966</b> , and that death occurred at <b>2:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Larry G. Tilley</b>		22b. DATE SIGNED <b>12/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Larry G. Tilley</b>		22d. ADDRESS <b>1713 Taylor Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Maryland</b>	
24. FUNERAL DIRECTOR <b>William E. Johnson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>DEC 12 1966</b>	



